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CHEMIST & DRUGGIST

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CHEMIST& DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

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REGULARS

COMMENT

Ever since the tribal shaman shook his first set of knuckle bones, quack remedies have been with us. It is a testament to people's eternal optimism (or gullibility) that the number is as great today as it probably was when Noah was a lad. Of course, now the packaging is better, and the health claims better informed, even if the outcome of 'treatment' is the same as it ever was. As our knowledge of what constitutes 'wellbeing' grows, so the spread of products claiming to promote health has grown. The public is keen to exploit the benefits that health supplements, and complementary and alternative medicine (CAM), hold out. Many pharmacists have benefited from this consumer trend and would admit to pushing scientific objectivity into the background to meet customer need. But 'caveat emptor' doesn't apply quite so brutally as it used to. Responsible elements in every area of trade attempt to protect consumers from themselves. The Joint Health Claims Initiative (see p6) is just such an exercise and deserves support. The critical Lords inquiry into CAM tackles similar 'grey areas' from a regulatory perspective, and promises to have a more impact (p5). There is already broad support for the licensing of herbal medicines along the lines proposed under the European Union Directive. More controversial will be the proposal that practitioners making specific claims for their ability to treat specific conditions should have evidence above and beyond the placebo effect. Where will this leave many alternative practitioners? Many pharmacists condone homoeopathic medicine on the basis that there is nothing in it and so it can do no direct harm. If it 'works', so much the better! Many complementary therapies also target the whole person (including their state of mind - a key component of much illnesses and frequently overlooked). This is a concept which regulatory systems struggle to deal with. There are no simple solutions here, but overall, much of what the Lords inquiry recommends makes sense.

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News

Scottish Minister praises pharmacy input into NHS Plan

The Scottish Health Minister, Susan Deacon, has told pharmacists they will have a valuable input into the NHS Plan for Scotland, due to be published on December 14.

Representatives of Scottish pharmacy organisations met the Minister recently to discuss the profession's future role, which will be incorporated in the overall Scottish plan rather than published as a separate strategy.

Ms Deacon wrote to the Royal Pharmaceutical Society in Scotland after the meeting saying she shared pharmacists' enthusiasm for developing their role. She was "delighted" with the profession's commitment to ensuring the success of the modernisation programme.

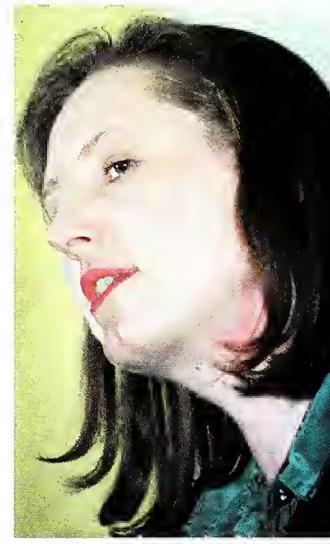
"I and my colleagues very much look forward to working together with you and your colleagues in order to make this a reality," she said in her letter.

"In your submission, you set out a number of highly practical suggestions on many issues that are central to the improvement of health and health services in Scotland: your clear and well-considered submission will play a valuable part in the preparation of the Scottish Health Plan.

"I am greatly impressed by the energy and enthusiasm of those such as yourselves who have taken the time from extremely busy schedules to contribute their ideas."

Pharmacy organisations submitted an eight-point plan, together with case studies illustrating 'patient journeys though the NHS' that could be improved by pharmacist involvement. Suggestions were:

- Patients stabilised on medication for chronic conditions should be able to have their repeat medication direct from their community pharmacist through a shared care package agreed between the patient, the GP and the pharmacist.
- Patients on long-term medication should have the opportunity for a medication review by the pharmacist, in agreement with the GP. This could be incorporated into pharmacists' NHS contract.
- Community pharmacists should be able to treat minor ailments on the NHS.
- Community pharmacies should be promoted as walk-in centres.
- Community pharmacists should be able to monitor patients on medicines requiring careful monitoring, such as anticoagulants.
- Greater involvement by hospital pharmacists in admission and discharge procedures would improve efficiency.
- Pharmacists should have a greater role in the management and implementation of LHCC strategies.
- The NHS Plan should explore models of remuneration for new pharmacy services, with the emphasis on patient care.



Susan Deacon

Three case studies show how the above proposals could help an elderly woman taking seven medicines for heart disease and osteo-arthritis, a young schizophrenic with difficulty taking his medicines, and a 50-year-old smoker with hypertension.

The chairs of the Scottish pharmacy bodies were to meet this week to discuss the next steps. Other organisations involved, besides the RPSiS, were the Scottish Pharmaceutical General Council, the Scottish Pharmaceutical Federation and the Association of Scottish Trust Chief Pharmacists.

Pharmacists on Tyneside write 'prescriptions' for OTC remedies

Pharmacists in the North East of England are helping to reduce GPs' workloads by writing 'self-care' prescriptions for over the counter medicines under a scheme starting this week.

Patients requesting an appointment at one of the three participating GP surgeries are offered a leaflet containing self-care advice and two tokens which may be exchanged for an OTC remedy recommended by the pharmacist.

The ailments covered by the scheme include cough, colds, flu, earache and stomach upsets.

The 13 pharmacies participating in the scheme receive a £250 honorarium and are reimbursed for the cost of the medicines. They also receive a £1.50 transaction fee per voucher.

"This scheme fits nicely with the NHS and Pharmacy plans in that it offers choice to the patient and enhances the role of the community pharmacist," said Dr Ian Spencer, project manager and head of primary care development at Newcastle & North Tyneside Health Authority.

The scheme, which is scheduled to last four months, is funded by the Tyne & Wear Health Action Zone and the Proprietary Association of Great Britain.

Clotrimazole going GSL for prevention of athlete's foot

The Medicines Control Agency is proposing that clotrimazole 1 per cent powder be added to the General Sales List for the prevention of athlete's foot. It already has a GSL licence as an adjunct in treatment of the infection.

In its consultation letter, MLX 267, the MCA also proposes to increase the maximum GSL dose of cetylpyridinium chloride from 3mg to 5mg for liquid oral preparations.

The MLX proposes that sodium fluoride becomes GSL for use in the prevention of dental caries. The proposed maximum strength of daily use mouth rinses is 0.05 per cent and in those for other than daily use, it will be 0.2 per cent. There are no safety issues involved because sodium fluoride is already used in strengths of up to 0.33 per cent in cosmetic preparations.

It is also proposed to add gum ammoniacum to the General Sales List.

The consultation process will end on January 12, and the MCA plans to implement the necessary legislative changes by March 2001.

Lloydspharmacy's hearty work

Lloydspharmacy is to work with the British Cardiac Patients Association, which has opened the country's first walk-in advice centre for coronary heart disease.

The BCPA centre in Crystal Palace is offering cholesterol testing and blood-pressure monitoring, as well as advice and information. Lloydspharmacy will be working closely with the BCPA throughout next year to raise awareness of heart disease.

Countdown's Richard Whiteley (left) opened the centre. He is pictured with Mike Bassett (right), key account executive with BHR Pharmaceuticals, which is supplying the test equipment, Eve Knight, BCPA liaison officer, and John Gregory, special services category manager

Condoms as well as free EHC

Condoms will be given away as well as Levonelle in an emergency contraception pilot in North Wales. Pharmacists are being recruited to take part in the trial, which is expected to start on February 14, 2001.

Bridgend Local Health Group is funding a project co-ordinator, community pharmacist Mrs Alex Aubrey, and will pay pharmacists £10 per intervention, plus the cost of supplies. Detailed proposals and the patient group directions are currently being drawn up.

The organisers were hoping all 12 pharmacies in the area would take part, but one has so far declined.

Women requesting emergency contraception will be counselled and either given Levonelle or referred to a GP or family planning clinic. All will be offered a free packet of condoms.

Derby EHC pilot extended

Derby's emergency contraception pilot has been extended from seven pharmacies to 17.

The scheme is funded by the primary care groups and run by Southern Derbyshire Health Authority. Pharmacists supply free EHC under patient group directions and receive the cost of the medicine, a £50 annual retainer, and a consultation fee of £10, whether or not they issue Levonelle-2.

Pharmaceutical adviser Rebekah Cooke told *C&D* that the scheme could be extended to more pharmacies but future plans depended on Levonelle's legal status.

NPA extends its internet offering

The National Pharmaceutical Association is extending its internet service with the addition of the web-enabled BNF and automatic access to the PSNC web site.

WeBNF, which is updated twice yearly in March and September, will be available free to NPAnet users. Members in England and Wales will also have automatic access to PSNCnet direct from the NPA's site without having to install separate software onto their computers.

In a further development, NPAnet users will be given the opportunity of a free 30-day trial and a reduced subscription to Martindale on-line early in the new year.

NPA members in England and Wales who have not yet registered on NPAnet will be sent a CD-rom this month that will enable them to log on (alternatively call the helpline on 020 8357 5757 and ask for a CD-rom to be sent immediately).

CPPE and BBC put pharmacists in the Learning Zone

Early birds can see the fruits of a collaborative venture between the BBC and the Manchester-based Centre for Pharmacy Postgraduate Education on BBC 2 on December 12, at 5.30am - or they can set their videos.

The programme, entitled 'Patients and Pharmacists Working Together', is aimed specifically at pharmacists. Inspired by the Government's 'Expert Patient' initiative, it looks at the benefits pharmacists can gain from listening to patients, who often have a wide knowledge of their condition.

Rob Swallow, the CPPE's assistant director, educational development, and the driving force behind the project, explains: "We wanted to alert pharmacists to the need to incorporate patients' own knowledge and expertise with their medicines into routine professional practice."

The programme is aimed particularly at pharmacists when dealing with patients on long-term prescribed medication. It has been shot using real patients and real pharmacists - Linda Bracewell of Baxenden Pharmacy in Accrington, and John Foreman and Tim O'Donoghue of the Greenlight Pharmacy in Euston, London.

Mr Swallow is keen to encourage feedback from pharmacists, other health professionals and patients. There is a special number to call - 0845 601 2946 - and all responses received before 2001 will be entered in a prize draw.

The 30-minute production was funded by BBC Focus, which brings together independent organisations to talk about their ideas and how they might fit into the Learning Zone, the network's early morning educational slot.

The programme is produced by Bristol-based Hummingbird Films, which won a tender based on a brief written by Mr Swallow. He says this might be a springboard for further educational TV programmes. There is potential for links with the Open University.

Accrington Observer & Times

Linda Bracewell, CPPE tutor and pharmacist at Baxendale Pharmacy, Accrington. The production team spent over four hours filming in the pharmacy

Lords' inquiry backs stricter controls on herbal products

More rigorous controls on herbal medicine and other complementary therapies are advocated in a report published this week.

The House of Lords Science and Technology Committee is concerned about the safety implications of an unregulated herbal sector.

"We urge that all legislative avenues be explored to ensure better control ...in the interests of the public health," the Select Committee says in its report on 'Complementary and Alternative Medicine', based on a 15-month inquiry.

The Committee acknowledges that consumers often have no way of knowing whether or not a herbal or natural product is licensed.

"We recommend that the Medicines Control Agency find a mechanism that would allow members of the public to identify health products that had met the stringent requirements of licensing and to differentiate them from unregulated competitors. This should be accompanied by strong enforcement of the law in regard to products that might additionally confuse the customer with claims and labelling that resemble those permitted by marketing authorisations."

The Committee supports moves towards a European Directive that would allow licensing of herbal medicines with evidence of traditional use rather than efficacy, providing they met standards of quality and safety (*C&D*, November 11, p5).

Any new regulatory system should respect the diversity of products used by herbal practitioners and allow for simplified registration of their stocks, the report says. In its evidence to the inquiry, the European Herbal Practitioners Association warned that too rigorous licensing of dispensing supplies could restrict practice to untenable levels.

The Committee's other recommendations include:

- The interests of the public will be best served by improved regulatory structures for many professions, with statutory regulation in some cases. Acupuncture and herbal medicine are at a stage where patients would benefit from practitioners being regulated under the Health Act 1999. Such regulation might also be appropriate, eventually, for non-medical homoeopaths.
- Only those complementary and alternative (CAM) therapies that are statutorily regulated, or have a powerful mechanism of voluntary self-regulation, should be made available through the NHS.
- Healthcare professions' regulatory bodies should develop clear guidelines on competency and training for their members taking part in CAM.
- Provision of CAM on the NHS should continue to be through referral by GPs or their equivalent in secondary or tertiary care.
- CAM therapies should attempt to build up an evidence base with the same rigour as required for conventional medicine.
- Practitioners making specific claims for their ability to treat specific conditions should have evidence above and beyond the placebo effect.
- There is a clear need for more effective guidance to the public on what does or does not work and what treatments are safe. Because there is no central information provision, the media and other unregulated sources have an undue influence. The obvious place to turn for balanced information is the NHS, including NHS Direct.
- The NHS R&D directorate and the Medical Research Council should, with dedicated funding, develop a few centres of excellence for research on appropriate disciplines. Companies producing products used in CAM should invest more heavily in research and development.

The report (HL Paper 123) is published by the Stationery Office (£15.50), while the supporting evidence is in HL Paper 118 (£33.50) and HL paper 48 (£22.40).

APPG backs hospital pharmacy medicines management

Parliament's All Party Pharmacy Group has written to health ministers highlighting how hospital pharmacists can ensure better use of medicines.

The report recommends that practices developed at St Thomas's Hospital pharmacy department in London should be implemented nationally. The group visited the pharmacy last month and was impressed by a scheme in which patients admitted to hospital continued taking medicines already prescribed, where appropriate, saving around £100,000 a year (*C&D*, November 11, p6).

The MPs say that, generally, when patients are admitted to hospital they bring with them an inexact medication history, their medication is discarded in favour of a new regime, and they receive little information on medicines. Pharmacists, despite their expertise in this area, spend little time with patients.

"This strikes us as wasteful, inefficient and unlikely to lead to optimal patient care," the report says.

St Thomas's has made significant progress in using pharmacists on ward rounds and the Government should offer explicit support for such initiatives, the report adds. Pharmacists at the hospital have also been providing anticoagulant therapy in outpatient clinics and GP practices, making around 300 patient visits a week. Similar practices could be developed for HIV patients, cardiac rehabilitation, oncology and paediatrics.

"The principle of hospital-based pharmacists using their skills in the community, in concert with GPs and community pharmacists, is attractive."

The group sees clear merits in St Thomas's competence-based model of pharmacy practice. Pharmacists are categorised according to experience – as junior, mid-grade and practitioner – so that their skills are used to best effect.

JHCI code on health claims launched

A Code of Practice for health claims on foods is to be launched next week.

The code has been developed by the Joint Health Claims Initiative, established in June 1997 as a joint venture between consumer organisations, enforcement authorities and industry bodies. The aim is to prevent the use of exaggerated, misleading and prohibited health claims.

The code applies to manufacturers, retailers and others involved in the supply, promotion or labelling of foods, drinks and supplements, when making claims to the general public that the product carries a specific health benefit. It aims to clarify the difference between health claims and medicinal claims, which are prohibited for foods. A medicinal claim is defined as a health claim that states or implies a food can treat, prevent or cure human disease.

Although voluntary, the code aims to clarify and augment existing legislation and to complement existing codes and guidelines. The code is managed by an administration body, which will provide pre-market advice to companies wishing to make health claims.

All health claims must be capable of substantiation. Companies must be able to show that the food contributes a significant physiological benefit when consumed as part of a normal diet, and that the claimed effect can be achieved by consuming a reasonable amount of the food on a regular basis. The effect must be maintained over a reasonable time, unless the claim is for a short-term benefit as with folic acid in pregnancy. Companies must also state how the effect is brought about, although the exact biological mechanism need not be fully understood.

Other points include:

- Any reference to a specific disease or to disease in general terms should be avoided as it is likely to imply a medicinal benefit.
- It is acceptable to refer to the maintenance of good health in general or of a specific part of the body.
- A health claim must not encourage excessive consumption of any food or disparage good dietary practice.
- Claims of synergistic benefit are acceptable, for example, the use of vitamin C to improve bio-availability of iron.

A section on borderline products gives examples of words and phrases that might imply prevention, treatment and cure of disease.

Further information on the code, which has the backing of the Proprietary Association of Great Britain, is available from JHCI's executive secretary, Melanie Ruffell, on 01372 822378.

Fulfil CE obligation by 'skilling up' for new services, urges Glover

It is time to 'skill up' to deliver new services to patients, now that the Government has said it is going to make better use of pharmacists' skills, says the Royal Pharmaceutical Society president, Christine Glover.

Pharmacists can offer many new services with only minor extra training, but it means they will need well-trained staff supporting them, to free them from the dispensary, said the president.

"At the moment the Code of Conduct requires you to undertake 30 hours' continuing education. In the near future you will have a mandatory requirement to fulfil this obligation," she told 150 pharmacists and their guests at The Oshwal Pharmacists 20th annual ball. "Linking this with developing services is a productive way to move you, your business and the profession forward."

Doctors, and shortly, nurses are required to revalidate to stay on their registers. "Make no mistake, pharmacists will have to as well," she said.

Pharmacists have to persuade the sceptics of the value of medicines management, she said. Poor drug management is costing the nation as much as diabetes or asthma. Some 30 per cent of elderly admissions to acute services are the result of poor drug management.

"We will, in a couple of years time, be managing repeat medication. That means 70 per cent of prescriptions will be under your control. The opportunity to manage some of these will be there. It is a short step from managing to reviewing the medication," said Mrs Glover.

With the Government looking at e-commerce, nurse-prescribing and primary care centres with their own pharmacies, "we have to have a change in our thinking about moving towards services and being less dependent on supply," she added.

An in-house raffle on the night raised £250 for the Society's Benevolent Fund and £500 for the Commonwealth Pharmaceutical Association's Pharmaid scheme. RPSGB president Christine Glover receives the donations from Mrs Kalpana Shah (right), watched by master of ceremonies, pharmacist Kiran Shah

PSNC briefs LPCs on pharmacy plan

The Pharmaceutical Services Negotiating Committee this week highlighted the areas of the Government's pharmacy plan that LPCs will need to consider.

Over 200 LPC representatives gathered in Birmingham for the PSNC's national conference on the NHS pharmacy programme. Issues on which they were briefed included:

- NHS Direct – LPCs need to consider how they will co-ordinate participating contractors and provide advice to contractors on areas such as IT, protocols and redesign of premises.
- One Stop Centres – LPCs will need to adopt a consortium approach when considering a pharmacy opening in a centre; this may reduce the impact on surrounding pharmacies.
- Out of Hours services – LPCs need to review current arrangements and present convincing new proposals to the health authority; they should also consider threats posed by doctor dispensing.
- Repeat Dispensing – the PSNC is asking LPCs to support its national case for 28 day supply and not to encourage local schemes.
- Medicines Management – all LPCs should be preparing bids for PCTs to consider.
- Local Pharmaceutical Service contracts – LPCs must stress the advantages of community pharmacies as service providers. LPS contracts will require new legislation so discussions should not be rushed.
- A new national contract – when the details are known, LPCs will be responsible for promptly informing contractors what will be expected of them.
- Control of Entry – LPCs should co-operate with the development of one-stop centres, in order to minimise the change to 'control of entry' rules.

N IRELAND NOTEBOOK

The murky politics of smoking

Having developed a keen interest in smoking, following a training event last year, I was intrigued to see the billboard advertisements currently appearing around Northern Ireland.

At first I thought the posters were advertising the dangers of smoking. How wrong could I be? These government posters are designed to stop cigarette smuggling because it depletes the coffers of much-needed tax revenue. Shock horror, 20 per cent of cigarettes are smuggled, which means that the Exchequer is losing £2 billion per year in the UK on this fraud alone.

It's strange to see the government supporting smoking so long as it does not lose money. Labour made much noise at the last election on a pledge to ban cigarette advertising, only to do a rapid U turn later!

The politics of tobacco have never been clean, proper or above board because of the huge money involved. In addition to the £10 billion a year in

> "About half of all smokers die of their habit, a quarter of them before the age of sixty"

indirect taxation, there are employment considerations. Locally, Ballymena, with its Gallaghers' factory, is an example.

About half of all smokers die from their habit, a quarter of them before the age of 60. It is fine to talk about freedom of choice, but few smokers want to smoke. They can't beat an addiction more powerful than heroin.

I truly felt that this government was committed to smoking cessation and implementing policy to effect change. Perhaps the experience with the fuel-tax lobby has ensured that government must remain certain of its tax revenue. Whether tax comes from activities that improve people's lives or kill them is not really relevant. The voter will not pay income tax of more than 23p in the pound, yet will demand all the securities expected in a modern society. It's not surprising that government has to deceive. I might feel better if the tax collected from cigarettes went directly to healthcare. Some chance.

Written by a practising Northern Ireland pharmacist

Xrayser

Topical Reflections

PGDs go national much sooner than expected

The usefulness of patient group directions could be tested a lot more quickly then I had ever envisaged, and without the facility to test the efficiency of their delivery.

Suddenly, from being *personae non grata* under the NHS, both pharmacists and Relenza have been accepted as helpful for high-risk flu victims.

Since the medication must be administered within 48 hours of the symptoms first appearing, the Department of Health has strongly suggested that PGDs for pharmacists and nurses are the most convenient and efficient way of patients getting Relenza.

However, despite the urgency of setting up the PGD, I am concerned that the consequences for community pharmacists are also addressed. This is not a service that can be delivered using present dispensing fees as a template for payment.

Each PGD completed must command an appropriate fee, and this must reflect both the time required and the professional role of the pharmacist. If delivery is required this must be at the discretion of the pharmacist, but the expense incurred must be reimbursed.

Finally pharmacists cannot be left with unused stock at the end of the season. If supply is by the normal route, then Glaxo Wellcome must put into place a mechanism for returning any unused stock for full credit.

I am excited about this development because, despite the time pressure of having a system in place across the busy Christmas period, community pharmacists at last have the opportunity to demonstrate their ability to co-operate and to deliver a much-needed service.

The Department of Health says the PGD route of supply is not mandatory, but there is a strong recommendation that community pharmacists should be involved.

It would be politically naïve for any primary care group to restrict supply to nurses and exclude community pharmacists from the system.

Muddying the waters

I am amazed how the cheapest of drugs can suddenly become like gold dust and even, as in the case of Isoniazid, now only supplied on a named patient basis.

However the original economics of manufacture – assuming the same volume of sales – should still apply, so when I received a letter of explanation from Penn Pharmaceuticals about the apparent confusion over the cost and reimbursement of Isoniazid, I was relieved.

But having read the letter I am now even more perplexed and, as a taxpayer as well as a contractor pharmacist, doubly concerned. I was reassured to learn that in future my invoice from Penn will be broken down into cost plus distribution on-cost, plus carriage and, despite Isoniazid being a category C drug in the Tariff, I will be fully reimbursed. What I am not told is how much I have been previously reimbursed when this clarification was not to hand! That is my potential loss but what about the taxpayer?

Unspecified regulatory problems have meant that the sole product licence holder, Norton Pharmaceuticals, has had to temporarily restrict supplies on named patient basis. Since the company does not possess the administrative structure to deal with these transactions, it has by competitive tender appointed Penn Pharmaceuticals as its agent.

According to the letter, I will be reimbursed a cost of £5.77 per 28 tablets of 100mg (which is a tenfold increase in cost compared with 1999) and, to add insult to injury, with an additional charge of £8.50 per 28 tablet pack, regardless of the quantity ordered, to cover the cost of administering the named patient system.

I am not a party to the detail of the tender bids but I now know that every 28 tablet pack of Isoniazid purchased, regardless of strength, is costing the NHS £14.27 whereas in 1999 it was 55p. And that is what Penn Pharmaceuticals and Norton call clarification.

Join the soapbox brigade!

Writing letters can be a bore, but sending e-mails is quicker and more fun! From this you may deduce that I am no longer a technological dinosaur.

I cannot reveal my personal e-mail address, but *C&D* has its own e-mail address at *Chemdrug@unitedbusinessmedia.com* Just address your thoughts for the attention of Xrayser and join the soapbox brigade!

RPSGB promotes uptake of smoking cessation audit

The Royal Pharmaceutical Society is encouraging pharmacists to make use of its smoking-cessation audit tool, which is freely available via its web site (*www.RPSGB.org.uk*).

David Pruce, audit development fellow at the Society, says: "The tool assists pharmacists analyse the help they give to people wanting to give up smoking and to measure the effectiveness of their interventions."

The tool was piloted in 25 pharmacies in the Bromley area. It was found that most of the participating pharmacists thought they had less impact in smoking cessation than did the patients involved. "The underlying message is that pharmacists should be confident when giving proactive advice and offering follow-up support," says Mr Pruce.

Longer term, the tool could be used as a standard against which pharmacists are paid, suggested Miriam Armstrong of the Pharmacy Healthcare Scheme. It aims to promote good practice, but may become a benchmark for pharmacy smoking-cessation services, she said.

The Society hopes that all pharmacists taking part in No Smoking Day will use its audit tool to evaluate their services during the following month. The resulting data can then be fed back to Mr Pruce, who will analyse the results and present the findings at a later date.

Other planned smoking-cessation activities that will involve pharmacists include a nationwide series of seminars, distribution of health promotion material, and a television advertising campaign.

The first in a series of smoking-cessation seminars promoting the pharmacist's role, which was held in Whitechapel, attracted more than 200 representatives from all branches of the Health Service. There are eight of these seminars planned at venues around the country. The next one will be held in the North West on January 16. Details of others will follow.

A television advertising campaign that advises smokers to choose between their pharmacist and a funeral director will resume in December and run until No Smoking Day. The Department of Health campaign will be shown on terrestrial television across all regions.

The Department of Health will be distributing its new smoking-cessation campaign materials through pharmacies in England in early December. Materials include helpline cards, an information sheet and an A3 poster.

Pharmacists targeted in Welsh quit smoking push

Welsh pharmacists are being targeted by the Health Promotion Division in Wales as part of its stop-smoking campaign, to be launched on January 3.

The Quit & Win 'recruiters challenge' hopes to encourage pharmacists, along with GPs and nurses, to enrol smokers in the competition.

Teams that recruit at least five smokers to the campaign will be entered into a draw with the chance of winning a long weekend for six in a luxury resort in Pembroke-shire.

The Wales Quit & Win Challenge 2001 will run until April next year and will give smokers who want to quit an extra incentive in the form of prizes. These include a Daihatsu Cuore Plus car and short European breaks.

More than 3,000 Quit & Win information packs are being distributed to health professionals in early December. To request a pack call 0800 169 0169.

● Vantage pharmacy staff are currently being offered training on smoking cessation. The programme, produced in conjunction with product manufacturers, covers product knowledge and the provision of advice.

AAH marketing director Ian Bray says the training is being made available now because in the run-up to the New Year many people consider giving up smoking. AAH's research suggests that of those still currently smoking, 70 per cent will have tried to stop, and half of these will have made at least three attempts to quit.

Lottery money supports smoking cessation initiative

Pharmacists in Tooting, South London, are taking part in a Healthy Living Initiative supported by £900,100 from the New Opportunities Fund, a National Lottery distributor.

A smoking-cessation programme is one of six projects aimed particularly at ethnic minorities. Pharmacists will supply five weeks' free nicotine replacement therapy and see clients every week for a month, spending two hours overall with each one.

About ten pharmacists expressed interest initially, but a more flexible approach is being investigated to attract those who are unable to spend as much time with each client.

Indrajit Patel, one the pharmacists helping to organise the scheme, said that structured counselling gives the best results, but there is evidence that a telephone call at the right time can help, as can encouraging a group of 'quitters' to support each other. The fee is still under discussion, but should be at least £20 a client.

Help will also be available to people using oral tobacco, and pharmacists will be on the look-out for patients with symptoms of chronic obstructive pulmonary disease who could be potential targets for smoking cessation.

Dr Tom Coffey, who chairs Tooting Primary Care Group, told *C&D*: "We hope that in two years' time virtually all smoking cessation will be run by pharmacists."

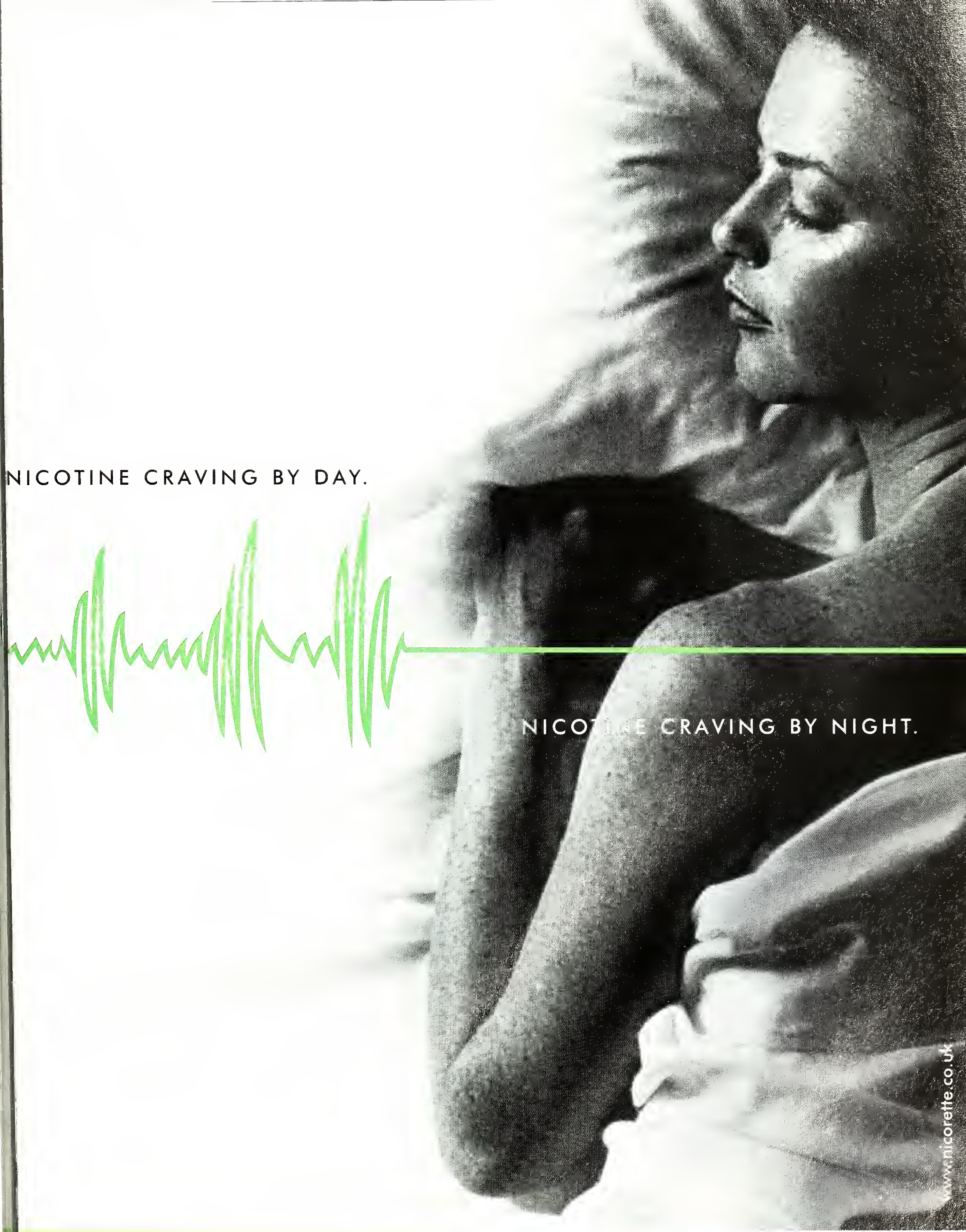
Other programmes in the healthy living initiative include heart disease, in which pharmacists could be involved in medicines management.

The Heartbeat Award scheme will highlight the importance of reducing salt and fat intake by rewarding local restaurants for healthy menus. Organised walks in the summer and swimming sessions will encourage people to take more exercise.

The Tooting award comes from the New Opportunities Fund's £300m healthy living centres programme.

● Tooting PCG is planning a repeat prescribing project in which pharmacists will inform GPs of prescription anomalies such as inequivalence in the amount of drugs prescribed, medicines that the patient has stopped taking and dosages that are out of line.

Pharmacists will be paid £1 per intervention, in an attempt to cut wastage.


NICOTINE CRAVING BY DAY.
NICOTINE CRAVING BY NIGHT.
www.nicorette.co.uk

Medical matters

IN BRIEF

Drug Tariff matters
The DoH and the National Assembly of Wales have agreed to allow NCSO endorsements for clomiphene 50mg tablets for December scripts. Vitamin B Compound tablets are deleted from Part VIII of the Tariff with effect from December prescriptions. The PPA says that glibenclamide 2.5mg tablets have been deleted in error from the December Tariff. The item continues to be reimbursed under Part VIII, Category A at a price of 96p per 28 calendar pack and will be reinstated in January 2001.

Fresenius launches Calshake
Fresenius Kobi has launched Calshake powder, a high-energy powdered supplement that is available on prescription (ACBS). It is available in banana, chocolate, strawberry and vanilla flavours. A box of seven sachets costs £12.36. Fresenius Kobi. Tel: 01925 898000.

'Understanding stroke'
Family Doctor Publications has added a new title to its series. 'Understanding stroke' is written by Dr Richard Lindley, a consultant physician and geriatrician. It retails at £3.50 (ISBN 1-898205-60-4). Family Doctor Publications. Tel: 01295 276627.

Cipramil drops return
Following a recall, Cipramil drops 40mg/ml are once more available. Lundbeck. Tel: 01908 649966.

Skin disease a major problem for the elderly

Up to 70 per cent of elderly people in the UK are suffering from skin diseases, many of which are preventable, according to a report.

The Associate Parliamentary Group on Skin's report claims that poor access to treatment and information remains a major cause of health inequality among people over 60 years old.

There is considerable potential for [illegible]re skin disease in the elderly to be [illegible]d in primary care, recommends [illegible]eport. It also recommends extend[illegible]se prescribing to link primary [illegible]ondary care.

[illegible] Walsall South and chairman [illegible], Bruce George, said: "We hop[illegible]port will be given serious consi[illegible] during the preparation of th[illegible] for older people."

Survey finds that one in ten children are taking drugs

Over 10 per cent of 11-15 year-olds have used drugs in the past year, according to a survey by the government body National Statistics.

Cannabis was the most popular drug, with 11 per cent using it in the past year. Less than 0.5 per cent had used opiates, and 1 per cent had used crack or cocaine.

The survey shows a slow but steady increase in the numbers of children using drugs. In a 1998 survey, only 7 per cent of this age group admitted using drugs during the previous month. Although not statistically significant, the results show increases among both boys and girls, particularly among those aged 14 and 15.

Drug use appears to be related to educational factors and anti-social behaviour. Over a quarter of children who said they did not do well at school had used drugs during the past year. And children who had used drugs recently were five times more likely to have been in trouble with the police or to have been excluded from school.

The survey of over 9,000 secondary school children from about 340 schools in England found that the number of regular smokers fell from 11 per cent in 1998 to 9 per cent in 1999. Drug use is strongly related to smoking experience, with 56 per cent of regular smokers using drugs in the last month.

There was no change in drinking levels between 1998 and 1999 - 21 per cent of children had drunk alcohol during the previous week.

PPA products must show more prominent warnings

The Committee on Safety of Medicines has recommended that the warnings on preparations with phenylpropanolamine in them should be more prominent.

The Medicines Control Agency has been advised to work closely with manufacturers to improve existing information on the packs and patient information leaflets of PPA-containing products. This is the only recommendation from a CSM meeting last Thursday that reached the same conclusions on safety issues as at a meeting earlier this month (*C&D* November 18 p8).

A DoH spokesman said: "PPA-containing products should not be used by certain groups, such as those with high blood pressure or heart disease. These warnings and contraindications are stated on the packaging and patient information leaflets."

AF therapies have equal effect

Controlling heart-rate and heart rhythm are equally effective for controlling the symptoms of atrial fibrillation (AF), according to a study in *The Lancet*.

The Pharmacological Intervention in Atrial Fibrillation Trial (PIAF) compared AF patients' symptoms after they had been treated with either diltiazem or amiodarone. Over 250 patients were randomised to either heart rate control using diltiazem (group A) or heart rhythm control using amiodarone (group B).

The end point was assessed by changes in the three most commonly reported AF symptoms - palpitations, dyspnoea and dizziness. Over the year-long observation period, a similar proportion of patients from both groups reported improved symptoms.

Hospital admissions were higher in group B (87 out of 127 patients) than group A (30 out of 125). Adverse effects more frequently led to a change in therapy in group B (25 per cent) than group A (17 per cent).

The study's authors concluded that their findings may have important implications for the care of AF patients who are treated mainly for symptomatic reasons.

Ulcer drugs now top BNF section by cost for GPs

Ulcer healing drugs are now the top BNF section by cost for GPs in England, accounting for 8 per cent of total prescribing costs.

The latest set of PACT data from the Prescription Pricing Authority shows that prescribing of these drugs has increased by 36 per cent over the last five years. This equates to increased spending of 14 per cent.

For the quarter to June 1995, almost two-thirds of prescriptions were for H2 receptor antagonists (H_2RAs) and one-third for proton pump inhibitors (PPIs). This pattern is now reversed, with PPIs accounting for almost three-quarters of spending in this category for the quarter to June 2000.

Omeprazole is the most frequently prescribed PPI, accounting for 49 per cent of items. It is followed by lansoprazole, which accounts for 41 per cent. Ranitidine accounts for 61 per cent of H_2RA prescription items, compared to 26 per cent for cimetidine.

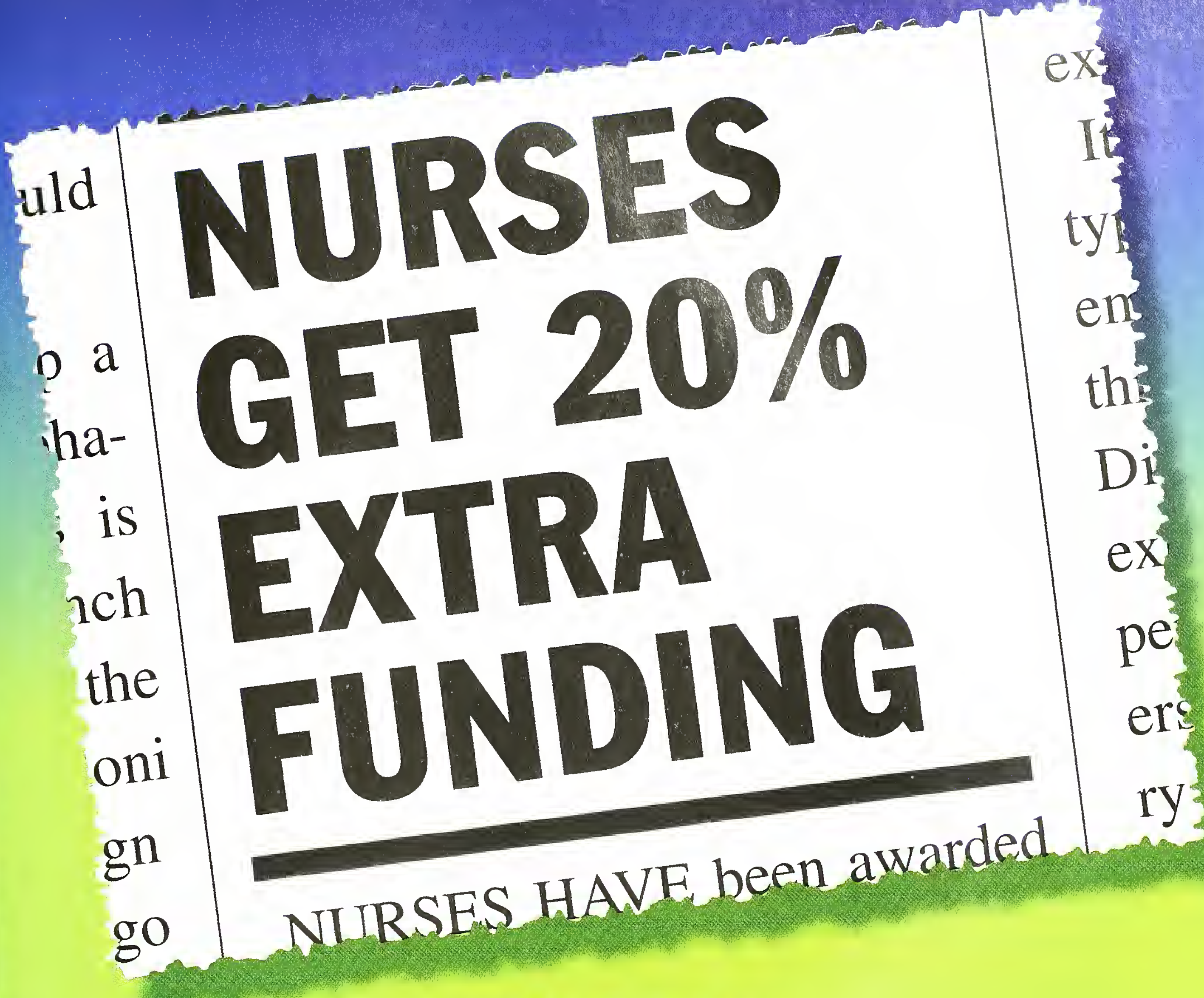
Prescribing of antacids and other related dyspepsia drugs has fallen by 10 per cent over the last five years, while prescribing of alginic acid preparations has hardly changed. Alginic acid preparations are the most commonly prescribed antacids, and spending on them has increased 16 per cent over five years.

About 10 per cent of the population ask their GP for advice on dyspepsia each year, and 10 per cent of these are referred to a specialist. The main causes of dyspepsia are:

- gastro-oesophageal reflux disease - 15-25 per cent
- gastric and duodenal ulcers - 15-25 per cent
- stomach cancer - 2 per cent
- non-ulcer dyspepsia - up to 60 per cent.

Leo launches tablets

Leo has launched Centyl K tablets, containing bendrofluazide 2.5mg and potassium chloride 573mg. They are licensed for treatment of oedema of cardiac, hepatic or renal origin, blood pressure control in mild to moderate hypertension, and prophylaxis against recurrent renal calcium stones. Basic NHS price is £5.44 for a pack of 56. Leo Pharmaceuticals Ltd. Tel: 01844 347333.



Record £2.4million advertising budget for 2000.

It's our highest advertising spend ever. But we're sure you'll agree they deserve it. After all, Night Nurse and Day Nurse is the No. 1 pharmacy only cold and flu brand.[1] And totally dedicated to maximising your profits this winter. With new 'embossed' packaging for increased standout, it's time to stock up now. And let these 'Nurses' take care of your customers and your business.

[1]Source: IRI. Night Nurse and Day Nurse are registered trademarks of SmithKline Beecham

DEDICATED TO PHARMACIES. DEDICATED TO COLDS & FLU.

Counterpoints

Acidex increases its liquid assets

Pinewood Healthcare is launching a liquid product to provide relief from the pain of heartburn and indigestion.

Acidex Compound Alginate Oral Suspension Heartburn and Indigestion Liquid is an aniseed-flavoured suspension.

The active ingredients are sodium bicarbonate, sodium alginate and calcium carbonate. The formulation is sugar and gluten free.

The product is suitable for adults and children over six years. It is also indicated for heartburn in pregnancy and may be used during lactation.

Retail price is £4.89.

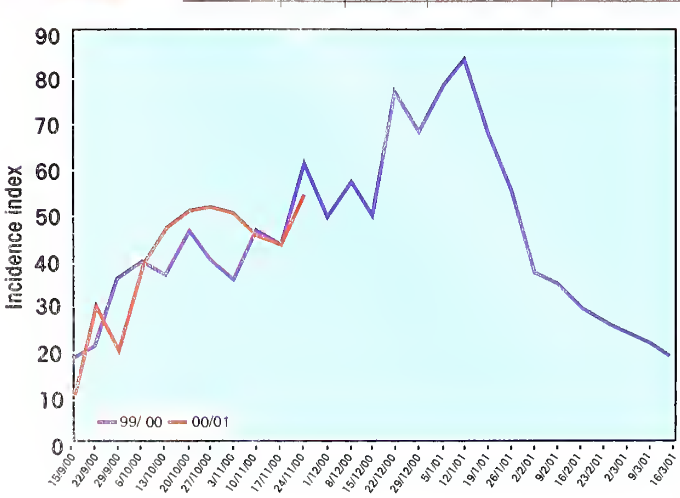
Pinewood Healthcare.
Tel: 00 353 52 36253.

Cough, cold & flu FORECAST

Information updated weekly by SDI

SPONSORED BY Benylin

United Kingdom	Status level	Number of weeks on status	Season 2000/2001 projected population affected by respiratory illness	2000/2001 vs. 1999/2000 cumulative season-to-date % difference
BIRMINGHAM	Advisory	7 weeks	162,089	12.23%
BRISTOL	Advisory	7 weeks	34,881	40.04%
GLASGOW	Normal	1 week	45,884	-35.81%
LEEDS	Advisory	8 weeks	113,029	18.83%
LONDON	Pre-Alert	1 week	714,818	-4.84%
MANCHESTER	Advisory	7 week	249,756	18.60%
NEWCASTLE	Pre-Alert	1 week	21,128	9.72%
NORWICH	Pre-Alert	1 week	11,910	6.55%



Night Nurse takes to the airwaves

SmithKline Beecham is supporting its Night Nurse pharmacy-only cold and flu brand with a £2.4 million TV and radio advertising campaign this winter.

Featuring a return of last year's upbeat Night Nurse commercial, the national TV campaign will run from December 4 until January 21.

This year, the same advertising theme will be used across both TV and radio to target the brand's core market - predominantly women aged 25-44.

PoS material to support the brand includes bunting, hanging banners, cubes, dummy packs and shelf edgers.

SmithKline Beecham Consumer Healthcare.
Tel: 020 8560 5151.

Getting back on top of the world with Alka-Seltzer

Bayer is supporting Alka-Seltzer with a £1.2 million Christmas marketing campaign.

TV advertising for Alka Seltzer will be on air for the next three weeks. Featuring a comical view of the planetary system, the commercial uses animations to show a hungover Earth bumping into planets .

The Earth breathes a sigh of relief as it gets back to normal, with the strapline 'Alka-Seltzer XS, for when you're not feeling on top of the world.'

The campaign also includes PoS material to complement the TV advertising. Shelf edgers, dump bins and counter units are available.

Regional activities target students and the youth market. These include a creative postcard campaign throughout London's top bars.

Bayer is introducing National Hangover Day on New Year's Day to promote Alka-Seltzer. The company will be offering drinkers advice on how to achieve a clearer start to 2001 through coverage in magazines and newspapers.

Bayer plc.
Tel: 01635 563000.

Gladiator Wolf gives Throaties a big-screen boost

Ernest Jackson is supporting its Throaties medicated throat pastilles with a £2 million cinema advertising campaign this winter.

The 'Big softies for sore throats' campaign, which was first shown last year, shows the softer side of the notoriously aggressive Gladiator 'Wolf'.

The commercial will be screened in cinemas throughout the country during December, January and February.

The campaign is targeted at females aged 15-24 who are the heaviest users of medicated confectionery.

Ernest Jackson & Co Ltd.
Tel: 01363 772251.

Licensed 50:50 Ointment

BCM Specials is launching 50:50 Ointment (50 per cent white soft paraffin, 50 per cent liquid paraffin) as a fully-licensed 'P' product. The ointment is indicated for symptomatic relief of dry skin conditions. Retail price is £11.40 for 500g.

BCM Specials.
Tel: 0800 952 1010.

SB broadens Aquafresh Flex with chunky handle

SmithKline Beecham is introducing a premium, chunky-handled toothbrush in its Aquafresh Flex range.

Aquafresh Max Active is an ergonomically-designed toothbrush with a two component rubber and plastic handle. It is available in two formats – X-Active with cross-angled bristles (lime green pack) and Concave with bristles that curve inwards (blue pack). Both feature a cleaning tip and medium textured bristles. Brushes come in four colours – orange, blue, turquoise and lilac.

The blister card packaging accentuates the S-bend flexible neck and chunky handle. Retail price is £3.49.

SmithKline Beecham Consumer Healthcare.
Tel: 020 8560 5151.

'Use your head' urges Brylcreem campaign

Sara Lee is supporting its Brylcreem men's haircare range with a national TV campaign throughout December.

The 'Use your head' commercial features Iddo, the star of BBC's new *Attachments* series. It shows Iddo going through his morning grooming routine, effortlessly styling his hair with Brylcreem before leaving – with a bag of frozen peas! The end frame of the commercial highlights Brylcreem Ultra Gel's recent award for best haircare product in *Maxim* magazine's Style Awards.

Ultra Gel, which glows under UV light, was launched in a limited edition version. UV Glow will be available in the UK in 2001.

Sara Lee UK Ltd.
Tel: 01753 523971.

Santo's natural nipple care for nursing mums

Santo Products is launching a natural nipple care ointment for nursing mothers.

Rafael Natural Nipple Care Ointment is formulated to rapidly soothe and nourish the nipple area. The company says 30 per cent of nursing mothers suffer from sore and cracked nipples.

The product's natural ingredients include oils of hypericum, wheat germ and extracts of chamomile and ginseng. Formulated to be a completely safe product for mother and baby, the ointment is non-toxic and contains no preservatives. There is no need to wipe the ointment off before the next feed.

Retail price is £5.76.

Santo Products Ltd.
Tel: 020 8952 0668.

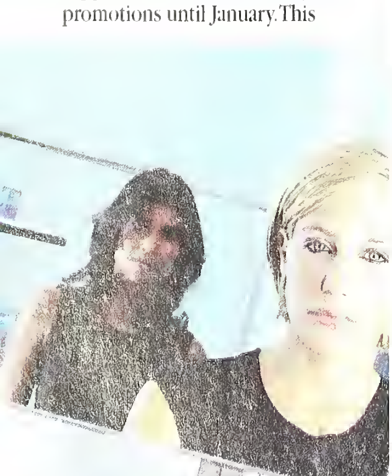
An eye opener from Optrex

Crookes Healthcare is launching a new initiative for its Optrex Fresh Eyes which is being teamed up with the Ruby & Millie cosmetics brand.

A consumer PR campaign featuring Optrex Fresh Eyes and Ruby & Millie will run until March. The campaign features photography by top fashion photographer David Woolley.

Optrex Fresh Eyes is also being supported with trade activity and promotions until January. This includes sampling through Ruby & Millie consultants in Boots the Chemists stores throughout December.

Crookes Healthcare Ltd.
Tel: 0115 953 9922.



Arden masks will Clear the Way

Elizabeth Arden plans to launch three treatment masks in its updated skincare collection in February.

Deep Cleansing is a deep-cleansing clay-based mask for oily skin. It contains extracts of birch bark, ginseng, watercress, calendula and cucumber.

Hydrating Mask is an intensely moisturising mask for dry skin. It is formulated with shea butter, camomile plus extracts of ginkgo biloba and kiwi fruit.

Clear the Way is a refining mask for normal skin. Its ingredients include algae extract and peppermint extract.

All three masks will retail at £15.00.

Elizabeth Arden Ltd.
Tel: 020 7574 2700.

ON TV NEXT WEEK

Aquafresh: All areas except U, CTV
Askit: GTV, GMTV, C4, C5
Avent Magic Cup: C, W, CAR, Sat
Beechams: U
Beechams Cold & Flu: All areas except U, CTV
Benylin: All areas
Calpol: ITV, GMTV, Sat
E45 & Skin Confidence E45: All areas except LWT, C4, GMTV, TSW
Gaviscon Advance: All areas
Haliborange: GMTV
Lemsip: All areas except CTV
Night & Day Nurse: All areas except U, CTV
Nytol: All areas
Panadol: U
Sensodyne toothpaste: All areas
Solpadeine: U
Sudafed: All areas except GMTV
Zantac 75 + Zantac 75 Relief: GTV, STV, C, C4, C5, TSW, Sat
Zovirax: C4, C5, ITV, Sat
Pharmasite next week: Motilium 10, Anadin – Window. Motilium 10 – Instore. NHS Direct, Canesten Thrush Cream – Dispensary

A Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

Pokémon vitamins for kids to chew on

Nutricia is supporting its recent launch of Sundown Pokémon multi-vitamins for children with press advertising and in-store PoS material.

The chewable children's vitamin brand, which was launched in the UK at Chemex in September, is being advertised in women's interest magazines until February.

Targeted at children aged four to 14, the range is designed to maximise on the current Pokémon craze among youngsters. Pokémon Multi, Pokémon with Iron and Pokémon with Extra Vitamin C come in four fruit flavours and are shaped and embossed with each of the four Pokémon characters. Each pack contains 60 tablets (two month's supply) and retails at £5.99.

Merchandising material includes a 48-unit floor display, an eight-unit gravity feed counter display, posters, mobiles, pamphlets and holders.

Pokémon is the first Sundown range to be launched in the UK following Nutricia's acquisition of US company Rexall Sundown. Nutricia is expected to introduce other Sundown vitamin and herbal supplements in the UK next spring.

Nutricia Ltd. Tel: 01225 711677.

Pharmacia to help smokers quit

Pharmacia & Upjohn will support its Nicorette range with a £2.7 million advertising campaign aimed at people who plan to give up smoking as a New Year's resolution.

A TV commercial focusing on Nicorette Gum will commence on Boxing Day and run throughout January.

Tube card advertising for Nicorette Gum and Nicorette Microtab will appear on London Underground trains for the last two weeks of December and the first two weeks of January.

A Pharmasite poster initiative featuring the Nicorette Patch, Nicorette Gum and the Nicorette Inhalator will run in pharmacies throughout January. PoS material to support the brand includes posters, giant packs, and counter units.

Pharmacia & Upjohn. Tel: 01908 661101.

Pro Plus awakes the festive spirits

Roche Consumer Health is supporting its Pro Plus brand for temporary tiredness with a regional TV campaign during December.

The campaign targets late night viewers in their battle against tiredness over the festive season – known to be the most tiring period of the year.

The humorous commercial features a weary shop cashier absentmindedly scanning items through the till – including a small dog!

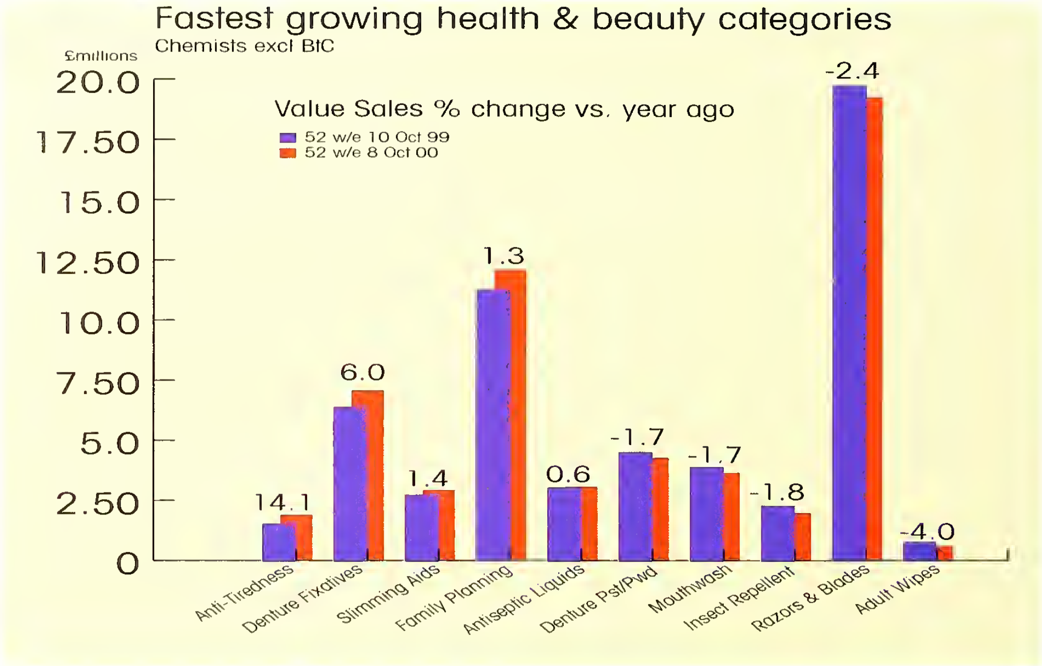
The advertisement ends with a short, sharp wake-up call for anyone dozing off in front of a TV screen.

It will be shown in London and the North between the hours of 11pm and 6am from December 4.

Roche Consumer Health. Tel: 01707 366000.

Market analyst Information Resources reports on how sales of health and beauty aids are performing in pharmacies

Supermarket sweep



As the prevalence of every day low pricing (EDLP) in supermarkets spreads, pharmacies are finding it increasingly difficult to compete on the price of toiletries and baby products.

In some cases where sales have increased in the supermarkets, it is clear that switching between store types has occurred.

However in other areas, the multiples are facing similar issues and it could be that the reduction in the value of the market has more to do with EDLP.

Kissing baby goodbye

Babycare products, and in particular nappies, have always had a strong presence in pharmacies. Yet, pharmacy sales of nappies have fallen by almost 30 per cent in the past year; customers are obviously buying them elsewhere.

Baby foods and drinks, which have struggled in pharmacies, are also seeing growth in the supermarkets.

Categories like vitamins and hair colorants, which have historically been large within pharmacies, remain prominent but are beginning to decline.

Niche pharmacy sales

While people increasingly buy toiletries with their grocery shopping, it is the niche markets that are growing in pharmacies.

Some areas are showing potential, albeit the smaller categories. Anti-tiredness is a prime example; it has been worth only £1.5m over the last year in chemists but has grown by 14 per cent.

This has been driven by the continued progress of Pro Plus. Despite having been available for over 40 years, it is only in the last few years that its use has increased significantly.

While Pro Plus is an all-purpose product, the manufacturers of Verve (Tagg NPD) have begun to produce a number of variants with a more specific target market.

Verve Female, Verve Mum To be and Verve Defence, to aid the immune system, have all started life on shelf promisingly. But the most successful Verve product has been the generic Verve Get Up & Go.

Grocery promotions

On the whole, oral care is another of the sectors moving the way of supermarkets. However, niche oral care products, such as dental fixatives, are retaining their market in pharmacies.

Procter & Gamble have only one brand in this market, but tellingly it is the number one single brand. Fixodent holds an 18 per share of the market and has grown by 10 per cent in the last year.

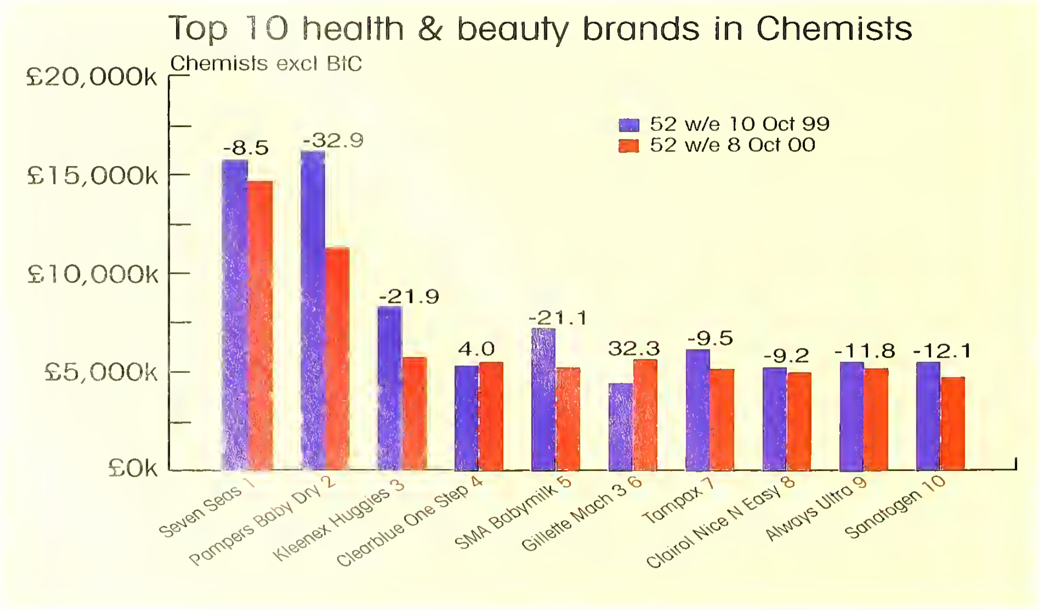
Stafford Miller dominates the market with a large range of products and has a 57 per cent share of the category. Poli Grip Ultra is its best-selling variant and while this has declined slightly over the last year, the growth of Super Poli Grip and Poli Grip Flavour Free have more than made up for the shortfall.

Few growing brands

Of the top ten brands in the chemist sector, only two are growing. One is the ubiquitous Gillette Mach 3 razor, but even its strong performance has not been enough to prevent the razors and blades category from declining within pharmacies.

The other is Clearblue One Step. The Clearblue brand was first launched in 1985 and within three months had become market leader, a position it retains 15 years on.

The One Step product was launched in 1988, providing a simple, accurate test result in three minutes. Despite being one of the more expensive brands available, it is by some distance the first choice of the consumer.



PHARMACYupdate

The wet ones

The water-soluble vitamins, B and C, are vital for normal physiological function. Nutritionist Esther Mills explains how they work and how deficient patients are affected

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1184), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JANUARY 13, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To recognise dietary sources of water-soluble vitamins
- To understand their mechanisms of action
- To appreciate their deficiency states
- To recognise groups particularly at risk of deficiency
- To be able to advise customers on supplementation

Water-soluble vitamins are vital for correct functioning of every single body cell and we rely on a constant supply from our diet to keep us healthy. The most famous of them all, vitamin C, was the first used to alleviate deficiency syndromes (in the case of vitamin C, 'curing' scurvy in 1747) and this paved the way for years of research into these fascinating compounds.

Today, nutritional science has established which vitamins can be classed as water soluble, their specific roles in the body, dietary deficiencies, contra-indications with medication and safe supplementary intakes.

Definition

Historically, much of the early work on vitamins began with identifying the chemical and physical characteristics of each particular nutrient. The discovery that factors in food could 'cure' diseases such as scurvy (vitamin C), beriberi (vitamin B1) and pellagra (vitamin B3) sparked scientific interest in isolating the compounds that gave health benefits.

This took many years of research into what were then called 'protective foods'. Vitamin C was first discovered in the late 18th century. But it was not until 1928 that 'water soluble C' was isolated and renamed ascorbic acid because of its chemical properties. Today, the classification 'water soluble vitamins' includes all B group vitamins and vitamin C.

Nowadays, biochemical research is determining the precise mechanisms of action of these nutrients. This is summarised in table 1.

Deficiencies

Improved nutrition, along with higher standards of hygiene and better standards of living, has brought great improvements in health since the end of the 18th century. Today, vitamin deficiency states are only very rarely seen in western societies.

There are clear guidelines as to what levels should be taken to prevent deficiency syndromes. In the UK, this is the Dietary Reference Value (DRV). It covers the average nutritional need, as defined by prevention of deficiency, of 97 per cent of the healthy population.

Marginal deficiencies are more common, and can have a profound effect on health before clinical deficiencies develop and are diagnosed. Many complementary approaches look for the warning signs of low

Continued on PII →

Table 1: Mechanisms of action of water-soluble vitamins

Vitamin B1 (thiamine)
Coenzyme for thiamine pyrophosphate required for the metabolism of carbohydrate, fat and alcohol
Vitamin B2
Forms the essential co-enzymes FAD (flavin dinucleotide) and FMN (flavin mononucleotide), required for converting proteins, fats and carbohydrates into energy
Vitamin B3 (niacin)
Niacin forms two co-enzymes, NAD (nicotinamide adenine dinucleotide) and NADP (phosphate form), which are fundamental to energy production
Vitamin B3 (pantothenic acid)
Part of Coenzyme A, a key enzyme required for energy production. Also required by the adrenal gland and in antibody formation
Vitamin B6
Forms part of the co-enzymes pyridoxal phosphate and pyridoxamine phosphate, required for energy production, protein and fat metabolism
Vitamin B12 (cobalamin)
Required for DNA synthesis – vital for cell production and formation of red blood cells.
Folic acid
Many roles. Required for synthesis of DNA and cell division. Required for production of methionine and glycine (non-essential amino acids)
Biotin
Involved in metabolism of carbohydrates and fats. (Needed for energy production). Specifically in lipogenesis (fat formation), gluconeogenesis (formation of glucogen) and metabolism of branched chain amino acids.
Vitamin C
Required for formation of collagen, for growth, tissue repair and wound healing, absorption of iron, formation for antibodies and stimulation of white blood cells, formation of corticosteroid hormones (adrenal gland).

Continued from PI

nutrient levels before clinical deficiency occurs.

From government dietary reports, clinical deficiencies of water-soluble nutrients are an extremely rare occurrence. Explained simply, low blood levels of water-soluble nutrients can result from three main causes – low dietary intakes, poor absorption in the gastrointestinal tract, or factors that increase requirements.

Table 2 lists deficiency syndromes for each water-soluble vitamin and people at high risk of illness. Both established orthodox research and complementory approaches are listed for comparison.

At risk groups

Research has identified those at high risk of nutritional deficiencies from water-soluble nutrients. The elderly, vegetarians and vegans on poorly planned diets, as well as people who eat little fresh produce, are at risk of deficiencies.

People with food allergies eating erratic diets over a long period of time may also develop nutritional deficiencies, especially if avoiding wheat produce (which is rich in B-vitamins), dairy or citrus foods.

Table 3 lists foods that are rich in the water-soluble nutrients. By following a diet rich in these nutrients, people guard against deficiency syndromes.

People with poor appetites, those on medication that interacts with water-soluble nutrients, or those with digestive disorders are also in danger of developing deficiencies of water-soluble nutrients (see table 4).

Supplementary uses

Sales of nutritional supplements have rocketed over the past five years. Mirroring this is a steady

Continued on PIV→

Table 2: Water-soluble vitamin deficiency syndromes

Vitamin B1
Orthodox – beriberi (oedema, lactic acidosis, peripheral neuropathy, tachycardia, enlarged heart, vasodilation, pulmonary congestion, venous distension), Wernicke-Korsakoff syndrome
Complementary – tender eyes, eye pains, irritability, poor concentration, 'prickly legs', poor memory, stomach pains, constipation, tingling hands, tachycardia
Vitamin B2
Orthodox – lesions in the mouth (angular stomatitis, cheilosis, atrophic lingual papillae, glossitis, and magenta tongue), skin lesions, surface lesions on genitalia and corneal vascularisation
Complementary – burning or gritty eyes, sensitivity to bright lights, sore tongue, cataracts, dull or oily hair, eczema or dermatitis, split nails, cracked lips
Vitamin B3
Orthodox – Pellagra (lesions on knees, ankles, wrists and elbows, dermatitis, diarrhoea, dementia with intermittent lucidity). Untreated deficiency is fatal
Complementary – lack of energy, diarrhoea, insomnia, headaches and migraines, poor memory, anxiety or tension, depression, irritability, bleeding or tender gums, acne
Vitamin B5
Orthodox – (experimental deficiency) fatigue, headache, dizziness, muscle weakness, gastrointestinal disturbances. No other evidence for deficiency. 'Burning feet syndrome', postural hypotension, impaired response of eosinophils to adrenocorticotropic hormone
Complementary – muscle tremors or cramps, apathy, poor concentration, burning feet or tender heels, nausea or vomiting, lack of energy, exhaustion after light exercises, anxiety or tension
Vitamin B6
Orthodox – inflammation of the tongue, lip lesions, lesions in the corners of the mouth and peripheral neuropathy
Complementary – sore skin, tingling hands, irritability, lack of energy, flaky skin, depression or nervousness, muscle tremors or cramps
Vitamin B12
Orthodox – nerve damage, pernicious anaemia (weakness, sore tongue, diarrhoea, ataxia, dementia and psychosis)
Complementary – lack of energy, anxiety or depression, poor hair condition, eczema or dermatitis, sensitive mouth, tender or sore muscles, pale skin, constipation
Folic acid
Orthodox – megaloblastic anaemia, often with leucopenia (low white blood cell count). Sensitive digestion, poor growth in children
Complementary – lack of energy, pale complexion, stomach pains poor appetite, depression, cracked lips, poor memory
Biotin
Orthodox – scaly dermatitis, hair loss, anorexia, nausea, hallucinations, depression, somnolence
Complementary – dry skin, poor hair condition, poor appetite or nausea, dermatitis, depression
Vitamin C
Orthodox – failure of hair follicle eruption, haemorrhaging on limbs, bleeding gums, impairment of connective tissue formation, poor wound healing
Complementary – bleeding or tender gums, easy bruising, lack of energy, frequent colds, slow wound healing, red pimples on skin, frequent infections

The Pharmacist & Smoking Cessation

WHY YOU SHOULD GET INVOLVED

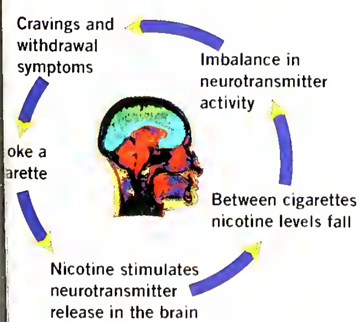
Smoking is the single greatest cause of preventable illness and premature death in the UK.[1] Seventy per cent of smokers say they want to quit[2] and each year 36% actively try[3], yet only 3% are successful when they rely on willpower alone.[4]

Helping people to quit smoking is now recognised as a top national and local priority. Pharmacists are often the first port of call for smokers thinking about quitting and they have an important role to play in supporting them. Recent research has shown that 1 in 6 people visit a pharmacist when they are planning to stop smoking.[5]

HELPING PATIENTS TO QUIT SUCCESSFULLY

It is now recognised that the majority of smokers do not smoke out of choice, but because they are addicted to nicotine. The power of this addiction was highlighted in the recent Royal College of Physicians report (February 2000), which states that nicotine is as addictive as 'hard drugs' such as heroin or cocaine.[6]

Cycle of Nicotine Addiction[7,9]



This is the main reason why so few smokers manage to give up without some form of help or support.[6] Motivation is vital in any attempt to quit, but it is rarely enough on its own. Pharmacological treatment, combined with advice and support, has been shown to be the most effective way to help motivated patients stop smoking.[4]

IDENTIFYING THE MOTIVATED QUITTER

Motivation is very important if an attempt at giving up smoking is to succeed. It is possible to quickly determine whether a smoker is motivated to quit by asking three simple questions:

1. **Do you want to stop smoking?**
2. **Is it important for you to stop?**
3. **Would you be prepared to stop smoking in the next 2 weeks?**

If the smoker answers positively to all three questions, they are motivated and they should be encouraged with help and advice.

Pharmacists are a primary source of advice for patients who may wish to use a pharmacological therapy to assist them in stopping smoking.

PHARMACOLOGICAL THERAPIES

Nicotine Replacement Therapy (NRT)

Until recently, the only licenced pharmacological treatment for smoking cessation was nicotine replacement therapy. NRT works by weaning the patient off nicotine through a controlled reduction in intake.[10] Overall, clinical trials have indicated that about 1 in 6 smokers (17%) who use NRT are not smoking a year later.[11] NRT approximately doubles cessation rates compared with a placebo.

NRT is not suitable for all patients.[10] It is currently recommended that some NRT products should be used with caution in people with heart disease or certain other conditions, including serious cardiac arrhythmias, systemic hypertension and peripheral vascular disease.[12-14]

ZYBAN ▼ (bupropion hydrochloride SR)

Zyban is the first non-nicotine therapy to be licensed for smoking cessation and offers a novel approach to treating nicotine addiction. The drug works in the brain by acting on the neurotransmitters involved in nicotine dependency and withdrawal[8,15] to reduce the craving for cigarettes and the withdrawal symptoms.[16,17] In a comparative study published in the New England Journal of Medicine, nearly 1 in 3 people (30.3%) who took Zyban were not smoking a year later.[16]

Zyban is a prescription-only medicine and should be prescribed as a two-month treatment course. Zyban is generally well tolerated.[16,18] The most common adverse events seen in clinical trials were dry mouth, headache and insomnia[16,18], all of which can also be associated with stopping smoking.[9,10] Zyban should not be prescribed to certain patients, e.g. those with a seizure disorder or a history of seizures, or those who have a current or previous diagnosis of eating disorders.

Every patient prescribed Zyban is offered support from the Right Time Programme, which includes tips and advice for quitting, motivational mailings and access to dedicated QUIT counsellors via a free helpline. (QUIT® is a national charity and their counsellors are all specialists in smoking cessation.)

THE ROLE OF THE PHARMACIST

Encouragement and support are vital for a successful quit attempt and pharmacists are often the first port of call for smokers planning to give up. Pharmacists play a key role in providing advice for smokers wanting to quit, together with tailoring treatment to meet the needs of individuals by recommending NRT or a referral to a GP.

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Table 3: Rich sources of water-soluble vitamins

Vitamin B1
Bread, cereal products, potatoes, milk and meat
Vitamin B2
Milk, meat, fortified cereals, eggs
Vitamin B3
Meat/meat products, potatoes, bread, fortified cereals
Vitamin B5
All animal products, grains and legumes
Vitamin B6
Potatoes, other vegetables, milk and meat
Vitamin B12
All animal products, certain algae and bacteria
Folic acid (folate)
Liver, yeast extract, green leafy vegetables
Biotin
found in a wide range of foods
Vitamin C
Potatoes, fruit juices, citrus fruits, green vegetables

Continued from PII

wave of interest in the use of supplements to improve health, rather than just prevent deficiencies.

Many orthodox scientists argue that western diets provide sufficient amounts of water-soluble nutrients and that supplements are unnecessary. Others, however, feel that supplementation provides consumers with a valuable means to improve their overall health.

Table 5 lists some common supplementary uses for the water-soluble vitamins, together with safety information and contra-indications.

Safe doses

It is well established that water-soluble nutrients are safer than the fat-soluble vitamins A, D, E and K. This is because they are not stored by the body and are efficiently processed by the liver. The body quickly absorbs water-soluble nutrients and easily eliminates excess from the body via the urine.

One water-soluble nutrient that has been in the limelight is vitamin B6. This followed government proposals to limit free sale of vitamin B6 to 10mg. This led to widespread criticism by consumers and industry alike who had followed guidelines laid down in the Shrimpton report.

The Royal Pharmaceutical Society has advised that pharmacists should consider how to advise customers requesting higher doses of pyridoxine, and that they should decide their own policy on the display of products containing daily doses of more than 10mg. Until legislation is finalised, industry continues to work to the upper safe limits (see Nutrient box).

Vitamin C steals the show

There have also been safety concerns about Vitamin C. Since its discovery in the 1700s, thousands of scientific studies covering both dietary and supplementary intakes have been published.

A report in *Nature* (April 1998) questioned the safety of vitamin C at 500mg daily intakes, the level chosen by the Ministry of Agriculture, Fisheries and Food as the most popular supplement intake.

More research is being carried out to determine the exact intake at which a pro-oxidant effect (the opposite of a beneficial antioxidant effect) predominates. Again, this signals the start of more stringent safety research into water-soluble nutrients and will no doubt come under the same scrutiny and controversy as vitamin B6.

References available on request

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.*

ACTION PLAN

1. The article talks about DRVs and Median Dietary Intake. Your reading will also have exposed the terms RDA and RNI. Find out the meanings of these terms and how they are related.
2. In your practice workbook list the products you sell containing each of the vitamins mentioned in the article. Show those products containing a single vitamin separately. Indicate how much they contain and if this is reasonable in terms of factors mentioned in the article.
3. Discuss the article with your staff and colleagues, and try to come to a consensus of what product and strength you should recommend for each vitamin. This will be complex especially when looking at combined products but try to develop a list of products for conditions presented by patients, eg tiredness, cold protection, treating a cold, lack of energy and so on.
4. Look at the complementary list provided. How do you feel about these indications?

Box: Nutrient intakes

	Median Dietary intake (daily)	Safe supplementary intake (daily)
Vitamin B1	1.7mg	100mg
Vitamin B2	2.0mg	200mg
Vitamin B3		
-amide	39.6mg	450mg
-acid	39.6mg	150mg
Vitamin B5	6.0mg	500mg
Vitamin B6	2.4mg	100mg
Vitamin B12	7.2mg	500mg
Folic acid	300mg	400mg
Biotin	37.5mg	500mg
Vitamin C	57.6mg	2000mg

Table 4: Risk factors for water-soluble vitamin deficiency

Vitamin B1
Chronically ill, anorexics, chronic alcoholics, people with intestinal malabsorption problems, and those undergoing renal dialysis
Vitamin B2
Anorexics, intestinal malabsorption, chronic alcoholism, biliary atresia, diabetics, patients on chloropromazine, barbiturates, and thiazide diuretics
Vitamin B3
Hartnup's disease (congenital defect affecting absorption of amino acids), carcinoid syndrome
Vitamin B5
Neither syndrome or causes have been clearly identified
Vitamin B6
Long-term use of isonazid or penicillamine, oral contraceptives, patients with Parkinson's disease taking levodopa, homocystinuria, chronic renal failure, coeliac disease, biliary obstruction and chronic alcoholics
Vitamin B12
Inadequate vegetarian and vegan diets, diverticulosis, Crohn's disease, inflammation of the ileum, ileal strictures or fistulas, scleroderma with abnormal gut motility, continued use of antibiotics
Folic acid
Elderly people with poor diets, alcoholics, coeliacs, multiple pregnancies, unsupplemented lactation, and haemolytic anaemia
Biotin
Improper use of total parental nutrition in hospitals. People consuming large amounts of raw eggs
Vitamin C
Severe coeliacs, chronic alcoholics, rheumatoid arthritis, anorectic patients with cancer, heavy smokers.

Table 5: Supplementary uses for water-soluble vitamins, with safety information and contra-indications

B Complex Vitamins – vegetarians and vegans (safeguard against deficiency), athletes (energy production, to meet the extra demands of intense physical activity), for maintenance of healthy skin, hair and nails, people with allergies (to safeguard against low intakes)
Vitamin C – healthy immune function, a healthy heart, as an antioxidant, in periods of stress, for healthy skin
Vitamin B1 – to guard against deficiencies caused by a high carbohydrate diet, high alcohol intakes, physical and mental stress
Vitamin B2 – prevention of deficiency (see Table 3). Causes yellow coloration of the urine. May affect the way cancer cells respond to methotrexate. To be taken apart from antibiotics (riboflavin is unstable in the presence of erythromycin and tetracycline)
Vitamin B3 – correction of deficiency, high cholesterol (under supervision), arthritis (joint conditions). At 20mg and more, nicotinic acid may cause flushing (dilation of the blood vessels). Nicotinic acid should not be taken by people suffering from gout, diabetes, stomach ulcers and liver disease
Vitamin B5 – Stress, allergies, arthritis
Vitamin B6 – Women on the pill, drinkers and smokers, women with pre-menstrual problems, nausea, maintenance of healthy nerve function. Not compatible with levodopa, phenytoin and phenobarbitone
Vitamin B12 – Treatment of anaemia, prevention of deficiency in vegans
Folic acid – Prevention of neural tube defects in foetus. For heart health, guard against deficiency in alcoholics, and for megaloblastic anaemia. At very high intakes, interferes with zinc absorption. Consult a GP if on drugs that inhibit folic acid (some cancer treatments) or on anticonvulsant drugs
Biotin – for dermatitis
Vitamin C – infections, after surgery and fracture, for dental and oral conditions, for anaemia (with iron), osteoarthritis, allergies. Corticosteroids, aspirin and birth control pills increase excretion of vitamin C. Dilutes the effect of tricyclic antidepressants. Acidic form not advised for people with kidney stones at intakes greater than 1g/day

No go zone

Constipation is a subject that pharmacists come across every day. The second in a series of articles taken from TESEMED, the European electronic self-medication programme for pharmacists, provides all the information they need

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 1185), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* JANUARY 13, PROVIDES ONE HOUR'S CONTINUING EDUCATION

OBJECTIVES

- To recognise causes of constipation
- To understand laxatives' mechanisms of action
- To recognise drugs that can cause constipation
- To know which laxatives are best for individual patients
- To be able to advise patients about laxatives

Constipation is defined as a decreased frequency of bowel movements, with hard stools often passed with difficulty and straining.

The normal frequency of bowel movements varies between individuals, from twice daily to once every two or three days. Constipation therefore, means different things to different people and it is important for the pharmacist to find out exactly what the patient understands by constipation to ensure that the problem is real.

Typically, there is accumulation of hard, dry material in the descending colon, so that reabsorption of water takes place over a long period, with the result that the faeces have a low water content. Reabsorption of water from the faeces may be due to:

- active transport of sodium
- absorption of bicarbonate ions into the duodenum and jejunum
- absorption of bicarbonate ions into the ileum and large intestine, with simultaneous absorption of chloride
- ion movement across the intestinal membrane.

Causes of constipation range from simple changes in lifestyle and daily routine to major bowel or systemic disease (see table 1). Medicines can also induce iatrogenic constipation (see table 2).

Constipation is a common problem for both the young and old

Referral situations

When one of the following symptoms occur, the pharmacist needs to refer the patient to their GP. This is important, as most of the major diseases that may give rise to constipation need urgent treatment.

General malaise

If the patient feels ill, weak and unable to work while constipated, they should be referred to a doctor to exclude any other organic causes.

If babies or older children become irritable, feverish, drowsy or have pain, eat less or vomit, they should be referred.

Blood in the stool

This symptom is not necessarily serious. If the blood appears fresh and is present only on the surface of the stool, it is most likely to have come from the anus or the distal part of the colon, probably because of straining.

Patients should be referred if:

- The blood is mixed with faeces giving it a dark colour often described as 'tarry'. This may have a more serious underlying cause such as diverticulosis, a bleeding peptic ulcer, or in rare cases a carcinoma.
- The blood appears as specks or as a light smear on the toilet paper after a bowel movement and a previous diagnosis of haemorrhoids or a similar condition has been made. Straining and hard stools due to concomitant constipation can cause or exacerbate haemorrhoids. In this case, a referral may also be necessary.

It is usually prudent to refer all patients with rectal bleeding for assessment of the cause.

Patients taking iron and bismuth tablets often have darkened stools, which is of no consequence.

Severe pain

Continuous or severe abdominal pain accompanying constipation, lasting for two days or more, usually requires a medical opinion. It could be due to bowel obstruction caused by a tumour, diverticular disease or irritable bowel syndrome.

Weight loss

Weight loss combined with constipation is common to many serious diseases, so it is advisable to refer to a doctor to exclude malignancy.

Diarrhoea

Although it sounds paradoxical, diarrhoea and constipation sometimes co-exist or alternate. In young adults, this situation together with abdominal pain is typical of irritable bowel syndrome. In elderly patients, such symptoms suggest diarrhoea secondary to faecal impaction.

Rectal tenesmus

Continuous painful and ineffective need to defecate. It could be due to irritable bowel syndrome or other major diseases.

Persistent symptoms or failure of OTC medicines

If symptoms persist for more than one to two weeks, or if self-medication with OTC medicines has not been effective, the patient must be referred.

Treatment

Constipation not caused by serious pathology will usually respond to simple measures. The first-line recommendation is to adopt an appropriate diet and lifestyle. Second-line treatment is laxatives.

Drug treatment

Continuous drug use – especially of stimulant laxatives – may result in a vicious circle where the contents of the gut are expelled, causing a subsequent cessation of bowel action for one or two days. This may give the impression that constipation has recurred, causing the patient to take more laxatives.

Chronic overuse of stimulant laxatives may result in loss of muscular activity in the bowel wall (atonic colon) and further constipation.

Continued use of laxatives can also lead to a psychological dependence. It is therefore important to stress that no treatment should be taken for a prolonged period.

It is important to find out whether the patient is suffering from any concomitant diseases. There are situations where straining may exacerbate the patient's condition (such as angina pectoris) or increase the risk of

Table 1: Causes of constipation

Diet and lifestyle
- Changes in eating, such as reduced fibre intake (particularly fruit and vegetables)
- Reduced overall intake, as in a diet or illness
- Reduced fluid intake
- Changes in lifestyle: job changes, loss of work or retirement, travel, changes in daily routine, stress, and lack of exercise

Disorders of the digestive tract
- Gastric disorders (eg cancer, gastric stricture)
- Intestinal disorders (eg diverticulosis, intestinal obstruction, irritable bowel syndrome, cancer of the colon, parasitosis, tuberculosis, syphilis)
- Rectal disorders (eg cancer, ulcerous proctitis)
- Anal disorders (eg fissures, abscesses, stenosis and complicated haemorrhoids)

Other conditions
- Pregnancy
- Endocrine and metabolic disorders (eg hypercalcaemia, hypothyroidism, uraemia, diabetes, porphyria and phaeochromocytoma)
- Neurological disorders (eg Parkinson's disease, medullary lesions, and cerebrovascular accident)
- Pulmonary disorder (eg chronic respiratory insufficiency, emphysema)
- Diaphragm dysfunction
- Muscular disorders, abdominal hernia
- Peritoneal disorders (eg ascites)
- Gynaecological disorders (eg ovarian cysts)
- Systemic conditions (eg malnutrition, anorexia, cachexia)

rectal bleeding (such as haemorrhoids).

Laxatives can be divided into five categories, according to their mode of action:
- Bulk laxatives
- Stimulant laxatives
- Osmotic laxatives
- Faecal softeners
- Lubricant laxatives.

Bulk laxatives

These include wheat bran, methylcellulose, ispaghula husk, and *Sterculia urens*.

Bulk-forming laxatives provide the closest approximation to the natural process of increasing faecal volume, and are normally the first line recommendation for functional constipation. They contain natural or semi-synthetic polysaccharides or cellulose derivatives that pass through the gastrointestinal tract undigested.

All bulk-forming laxatives are more or less equally effective, but patients find some preparations more palatable than others.

These products increase faecal volume in order to stimulate peristalsis. They work through three different mechanisms.
- The first action is to add directly to the volume of the intestinal contents; bran consists almost entirely of water-insoluble fibre and acts in this way.
- Other bulk-forming laxatives contain mucilloid constituents that bind to water and swell in the colonic lumen forming a gel, thereby softening the faeces and increasing their bulk. This is the case for ispaghula husk (consisting of the seeds of various species of plantago), linseed, psyllium seed and sterculia (also known as indian tragacanth or karaya gum – from the tropical shrub *Sterculia urens*). Methylcellulose, which forms a semi-synthetic hydrophilic colloid, has a similar action.
- Bulk laxatives also add to faecal mass by acting as substrates for the growth of bacteria in the colon.

Usage and administration

These types of laxatives should not be taken immediately before going to bed. This is due to the risk of oesophageal blockage.

They have a slow action, usually acting within 24 hours, but two or three days' medication may sometimes be required to achieve their full effect.

Bulk laxatives are often recommended in patients with inadequate fibre intake, or suffering from an irritable colon syndrome or haemorrhoids, or in the management of elderly people.

Cautions and contra-indications

Bulk-forming laxatives should be avoided if the patient suffers from a diverticular disease or bowel obstruction.

As they are not absorbed, these laxatives have no systemic effect and usually do not interact with other medicines. However, they can interfere with the absorption of some ingredients like digoxin and nitrofurantoin.

There is a risk of oesophageal and intestinal obstruction if preparations are not taken with plenty of water.

Bulk-forming laxatives may cause discomfort if taken in the later stages of pregnancy, as abdominal distension and flatulence are possible side effects.

Some products contain glucose, which needs to be taken into account for diabetic patients. Bran contains gluten and should not be taken by patients with coeliac disease or gluten enteropathies. The sodium content of bulk laxatives should be considered in people requiring a restricted sodium intake.

Stimulant laxatives

Stimulant laxatives can be divided into two main groups based on their different chemical structures and nature of the ingredients. Some of the best known ingredients are:

Anthraquinones
Senna
Aloin
Frangula
Cascara
Powdered rhubarb

Diphenylmethane derivatives
Bisacodyl
Sodium picosulphate
Phenolphthalein.

Among the traditionally-used stimulant laxatives, castor oil has fallen into disuse because of its 'drastic' action and unpleasant taste.

Mode of action

Stimulant laxatives are believed to stimulate nerve endings in the nerve plexuses of the bowel wall, increasing peristalsis. This is achieved through one or both of two possible mechanisms.

The first is inhibition of the 'sodium pump' (the enzyme sodium/potassium adenosine triphosphatase [Na+K+ATPase]). Inhibition of the sodium pump prevents sodium transport across the intestinal wall and leads to the accumulation of water and electrolytes in the gut lumen.

A second mechanism is increased production of fluid in the intestine through the action of the laxative on cyclic adenosine monophosphate (cyclic AMP) and prostaglandins, which promote active secretory processes in the intestinal mucosa.

It is also thought that stimulant laxatives may cause direct damage to mucosal cells thereby increasing the permeability of these cells and allowing fluid to leak out.

Usage and administration

Stimulant laxatives are usually taken at bedtime to produce an effect the following morning. Suppository presentations (eg bisacodyl) produce much faster results, usually within an hour.

The length of time for individual stimulant laxatives to take effect varies according to their site of action, which may be in the small intestine, the large intestine or both. But they normally work within 4-12 hours of administration.

Cautions and contra-indications

The main adverse effects of stimulant laxatives are griping and intestinal cramps. Prolonged use may result in fluid and electrolyte imbalance, and loss of colonic smooth muscle tone. This in turn may lead to a vicious circle in which increasingly larger dosages of laxatives are needed to produce evacuation until eventually the bowel ceases to respond at all and constipation becomes permanent.

Stimulant laxatives should be avoided in the first quarter of pregnancy. Anthraquinones are secreted in breast milk, and large dosages may cause increased gastric motility and diarrhoea in breastfed infants. Breastfeeding mothers should, therefore, avoid this class of laxative.

Anthraquinone glycosides are excreted via the kidney and may colour the urine a yellowish-brown to red colour, depending on its pH.

Although many stimulant laxatives carry dosage schedules for children, they should be used with caution.

Anthraquinones

Anthraquinones are naturally occurring glycosides used in the form of standardised plant extracts. They are believed to act through a combination of direct stimulation of the intramural nerve plexus and interference with absorption of water across the intestinal wall. The effects of individual preparations vary according to the speed of hydrolysis of the glycosides they contain and their anthraquinone constituents.

Senna is obtained from the dried leaves or pods of *Cassia senna acutifolia*, or *Cassia angustifolia*. Preparations are usually standardised to the content of sennoside B (7.5mg per tablet or per 5ml syrup). The use of senna pods should be avoided.

Aloin is an extract of aloes. It has a similar but more drastic action to senna and is more irritant.

Other anthraquinone plant derivatives used in non-prescription laxative products include powdered rhubarb (a 'soft' laxative), frangula from the bark of *Rhamnus frangula*, and Cascara from *Cascara sagrada*.

Diphenylmethane derivatives

Bisacodyl acts mainly via stimulation of the mucosal nerve

Continued on PVIII →

Continued from PVII

plexus of the large intestine, so takes rather longer to act (six to 10 hours after oral administration) than laxatives that act within the small intestine. The action is faster if taken as a suppository (from 20 minutes to one hour).

It is minimally absorbed and appears to exert no systemic effects. As bisacodyl causes gastric irritation, it is not available in liquid form and tablets are enteric-coated.

Sodium picosulphate, structurally related to bisacodyl, becomes active following metabolism by colonic bacteria. It therefore has a relatively slow onset of action, usually acting within 10 to 14 hours. It can be used in young children.

Phenolphthalein used to be one of the most common ingredients in laxative products marketed for non-prescription medicines sale, but due to its adverse effects it has been retired from the market in most European countries.

It is a chemical closely related to bisacodyl and sodium picosulphate. The medicine is partly absorbed in the intestine, taken up by the bile salts and repeatedly recycled through the liver, so that a single dose may exert an effect for several days. Phenolphthalein commonly causes a rash and colours the urine pink and faeces red, which may alarm patients. Adverse effects including albuminuria and haemoglobinuria may also occur.

Osmotic laxatives

The most commonly used osmotic laxatives include magnesium hydroxide, sodium potassium tartrate, lactulose and glycerol.

Mode of action

Osmotic laxatives are either inorganic salts (magnesium hydroxide), or organic ingredients (lactitol, lactulose, glycerol). Like the bulk laxatives, they retain fluid within the bowel to stimulate peristalsis and the formation of a soft stool.

They are poorly absorbed from the intestine, where their presence creates a hypertonic state. In order to equalise osmotic pressure, water is drawn from the intestinal wall into the lumen, raising the intraluminal pressure by increasing the volume of the contents. This stimulates peristalsis and promotes evacuation. They tend to have a more powerful action than the bulk laxatives.

Usage and administration

The inorganic salts produce effects within three hours. They are also believed to act through stimulating the secretion of the hormone cholecystokinin, which promotes fluid secretion and motility in the intestine.

Lactulose is a synthetic disaccharide. It takes much longer to act than the inorganic osmotic laxatives, as it first has to be broken down by colonic bacteria, mainly to lactic acid. This produces a local osmotic effect.

It may take 72 hours of regular dosing to produce an effect. It has a sweet taste which makes it more palatable for children, to whom it can be safely given, but many adults find the larger volumes required (up to 30ml) sickly and a deterrent to compliance.

Glycerol is a highly hygroscopic trihydric alcohol. Administered as suppositories, it is believed to act by both a local osmotic action and a stimulant effect. It can be confidently recommended for children and should produce a bowel action within one or two hours.

Cautions and side effects

Some absorption of inorganic laxative salt ions does occur, but in normal healthy individuals the amounts are too small to cause toxic effects, and the ions are rapidly excreted via the kidneys.

However, accumulation of magnesium ions can occur in the presence of renal impairment, causing toxic effects in the central nervous system and altered neuromuscular function through hypermagnesaemia. Except as single treatment, inorganic laxatives are best avoided in patients with chronic renal disease. As renal function tends to decline with age, it may be advisable to discourage regular use by elderly patients.

The main side effects of inorganic osmotic laxatives are nausea and vomiting. In addition, large dosages can produce significant dehydration, so sufficient water should always taken.

Serious adverse effects with lactulose are rare. Relatively minor side effects, although they may be sufficient to discourage compliance, occur in about 20 per cent of patients taking full doses and include flatulence, cramp and abdominal discomfort, particularly at the start of treatment.

Lactulose is a disaccharide of galactose and fructose, and includes some lactose. It cannot, therefore, be used by patients with galactose or lactose intolerence, and must be used with caution in patients with diabetes.

Faecal softeners

Docusate sodium is an anionic surfactant that acts by lowering the surface tension of the intestinal contents. This allows fluid and fat to penetrate, emulsify and soften faecal material for easier elimination. The faeces are kept

Continued on PXI →

Table 2: Drugs that cause constipation

- Antacids: aluminium salts
- Antiepileptics: phenytoin
- Antiemetics: 5-HT3 antagonists including ondansetron, granisetron and tropisetron
- Antihypertensives: clonidine, prazosin, methyldopa, verapamil, and beta blockers
- Antiparkinsonians: levodopa, specific anticholinergics such as biperiden, procyclidine, and trihexyphenidyl, and non-specific anticholinergics such as diphenhydramine, and benzatropine
- Orally administered iron salts
- Atropine and its derivatives
- Tricyclic antidepressants and MAO inhibitors
- Antitussives: opiates such as codeine, dextromethorphan and dihydrocodeine
- Diuretics (when they cause dehydration)
- Antidiarrhoeals (when used inappropriately)
- Opiate analgesics
- Neuroleptics: dibenzodiazepines such as clozapine, olanzapine, and phenothiazines such as chlorpromazine, thioridazine, pipotiazine, trifluoperazine, and fluphenazine
- Cytoprotectants: bismuth salts, sucralfate
- Cationic resins: cholestyramine

TESEMED is an electronic self-medication training programme for pharmacists that has been developed in Europe.

The programme is part of a European Commission research programme aimed at improving the public's health knowledge and self-medication throughout Europe. The European organisations representing community pharmacists (PGEU) and the manufacturers of non-prescription medicines (AESGP) are both involved in the project.

Pharmacists are invited by TESEMED to use its web site. the address is *www.imim.es/tesemed*

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BAKER NORTON

Continued from PVIII

soft, and evacuation is achieved without straining. Docusate is also thought to exert a stimulant laxative effect similar to that of the anthraquinones.

Docusate is non-absorbable and non-toxic, but is believed to facilitate the transport of the medicines, including liquid paraffin, across the intestine and could thereby increase its action and adverse effects.

Usage and administration

A laxative effect usually occurs within one to three days of administration. Used alone, docusate is a weak laxative, but it is considered useful for patients in whom straining at stool must be avoided (for example, following an operation or a myocardial infarction, or in patients suffering from hernia).

Faecal lubricants

Liquid paraffin is indigestible and absorbed only to a small extent. It penetrates and softens the faeces, and coats the surface with an oil film, which facilitates its passage through the intestine.

It is considered to have a usefulness as an occasional laxative in situations where straining at the stool must be avoided, but it has several drawbacks which make it unsuitable for regular use.

Cautions and side effects

Liquid paraffin can enter the lung through aspiration and cause lipoid pneumonia, so it must not be administered at bedtime or to very young, elderly or debilitated patients. Liquid paraffin may interfere with the absorption of fat-soluble vitamins A, D, E and K.

Decreased vitamin K absorption is particularly significant for patients taking oral anticoagulants, as their effect may be increased. It is slightly absorbed into the intestinal wall where it may set up foreign body granulomatous reactions. Liquid paraffin may seep from the anus and cause irritation. It should be avoided in cases of abdominal pain, nausea or vomiting, and should never be used for children.


The elderly often avoid high-fibre foods that are difficult to chew

Hygienic measures

Dietary fibre is the treatment of choice for constipation. However the side effects of a high-fibre diet (including bloating, flatulence and irregular bowel movements) may reduce patient compliance. Fibre intake is generally lower in the northern countries than in the countries of southern Europe.

Since low fluid intake also plays an important role in constipation, the patient should drink at least 1.5l of fluid a day, with increased intake in the summer.

Regular bowel movement and physical exercise are important. In case of limited mobility, simply maintaining an upright position may be helpful.

Application of Vaseline to the anal region before defecation is a useful measure to reduce the pain and irritation caused by passage of the dry hard faeces.

Special patient categories

Pregnancy and breastfeeding woman

It has been estimated that one in three pregnant women suffers from constipation. The main cause of constipation in pregnancy is the increased quantity of circulating progesterone (especially during the second and the third trimesters). This causes relaxation of the smooth muscle of the bowel which, together with the physical compression of the bowel by the growing uterus and the effects of iron therapy, often results in constipation.

Bulk laxatives can be used in pregnancy, as can stimulant laxatives, although the latter are to be avoided in the first quarter. Breastfeeding women should not take anthraquinones as they are secreted in breast milk.

Children

Breastfeeding babies normally produce fewer stools than bottle-fed babies. This is perfectly normal and does not require any intervention. Constipation in a bottle-fed baby may be caused by insufficient water being added to the milk powder.

If babies or older children become irritable, feverish, drowsy, have pain, eat less or vomit they should be referred. If none of these situations apply, it could be sufficient to add more fibre to the diet as children usually respond better and quicker than adults to dietary changes.

The elderly

Constipation is a common problem in elderly patients for several reasons. The elderly are less likely to be physically active. They often have poor or false teeth, and so avoid high-fibre foods that are more difficult to chew. Many suffer from medicine-induced constipation. Muscle tone in the bowel is usually reduced with increasing age, and faecal stasis may occur.

Elderly patients are often obsessed with 'regular' bowel movement and are therefore more likely to take laxatives not only to restore normal bowel function, but also to prevent constipation. This in turn may lead to laxative abuse that can result in chronic constipation and damage bowel muscle tone.

Nevertheless, constipation in the elderly should be taken seriously as it may indicate dehydration. A bowel filled with impacted faeces may compress adjacent structures such as the urinary tract and cause urinary retention. When this occurs, bulk laxatives are recommended. However, it is important that a proper diet or sufficient fluid intake to prevent a bowel obstruction is recommended.

C&D is accredited by the College of Pharmacy Practice as a provider of distance learning until March 2001.

ACTION PLAN

1. Over the next four weeks record in your practice workbook by condition (eg constipation, cold, corn) all patients you provide with a response to a symptom.

2. Analyse this list and note the percentage of consultations for each condition

3. Also record the number of times you sell a laxative both from a direct request and on your advice.

4. Do you suspect there are patients who may be laxative abusers? If so, what do you do? Discuss this with local colleagues. Would it be advantageous for pharmacists in your locality to cease to supply such abusers?

5. What is the drastic action of castor oil? Find out.

6. Why are stimulant laxatives taken at night? Is there a sound reason?

7. Some experts are questioning the practice of using lactulose so freely in the elderly. Why?

PHARMACYupdate: distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. With the support of Genus Pharmaceuticals, C&D's readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the January 13 issue, which will cover this week's CPP-accredited modules, together with those in the December 16 issue.

The MCQ paper for the November modules will be enclosed in next week's C&D covering:

- Haemorrhoids (1181)
- Trace elements (1182)
- Multiple sclerosis (1183).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply). A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

C&D in association with

GENUS PHARMACEUTICALS

The Young Ones

Extra care is required when dispensing medicines for children. Recent recommendations concerning the use of medicines that are not licensed for use in children are presented here

Guidelines on using medicines in children were produced last year by a joint committee of the Royal College of Paediatrics and Child Health and the Neonatal and Paediatric Pharmacists Group. They were first published in the national paediatric formulary 'Medicines for Children'.

The Committee recommends that those who prescribe for a child should choose the medicine that offers the best prospect of benefit for that child, with due regard to cost.

It also makes recommendations with regard to:

- licensing
- information
- consent
- NHS Trust policies.

Licensing

The informed use of unlicensed medicines or of licensed medicines for unlicensed applications is necessary in paediatric practice.

1. Children may be prescribed unlicensed medicines or medicines that have only been licensed for use in adults when there is no suitable alternative.
2. The Medicines Act includes exemptions, which enables doctors to:
   - Prescribe unlicensed medicines
   - Use unlicensed products specially prepared, imported or supplied in 'named patients'
   - Use medicines in clinical trials
   - Use licensed medicines for indications, doses, or routes of administration, outside the licence
   - Override the warnings and the precautions given in the licence.
3. In each case the doctor has to be able to justify the action taken as being in accordance with a respectable, responsible body of professional opinion.

Information

It is essential that health professionals should have ready access to sound information on any medicine they prescribe, dispense or administer, and on its availability.

1. When the medicine is unlicensed, information on the use of the product will not be available in the marketing authorisation and must be sought elsewhere. Information is often available, although it might not be easily accessible.
2. To meet the need for accessible information and guidance the Committee has prepared a new formulary – 'Medicines for Children'.
3. Parents, patients and teachers need information about medicines from health professionals, including pharmacists. The information must be given in an understandable manner, and be accurate and consistent. This is particularly important when the specialist hands over the care of the patient to someone else. Given the complexity of some of the information, there is a need for practical communication arrangements as well as available reference sources.

Consent of parents, carers and patients

We consider that in general it is not necessary to take additional steps, beyond those taken when prescribing licensed medicines, to obtain the consent of parents, carers and child patients to prescribe or administer unlicensed medicines or licensed medicines for unlicensed applications.

1. Health professionals must respect the right of children and their parents to participate in decisions on the child's care, and ensure that those decisions are properly informed.
2. The drug's licence status should not be seen to reflect what is, or is not, best for the child. Doctors are aware of a possible impact upon parents' confidence, who then might be reluctant to accept advice. As a consequence, a child might not receive a medicine that offers benefit.
3. The Committee has produced generic patient information leaflets for patients and parents. These leaflets are available to health professionals via the Royal College of Paediatrics and Child Health's web site – *www.rcpch.ac.uk.library* They explain why it may be necessary to prescribe unlicensed medicines or to use licensed medicines for unlicensed applications. The generic leaflets have been produced because medicines used for unlicensed applications may include a patient information leaflet warning against such use.
4. There are circumstances when a clinician will decide to give fuller information than is usually necessary. These may arise when a medicine is new, carries possible risks of harm, or when the concerns of some parents or patients require a more detailed explanation of the medicine. In each instance, practice is guided by clinical judgement.

Policies of NHS Trusts

We consider that NHS Trusts should support therapeutic practices that are advocated by a respectable, responsible body of professional opinion.

1. Some NHS Trusts have suggested that clinicians should not use medicines for unlicensed applications. The Department of Health does not expect health authorities to restrict a clinician's freedom to prescribe by directing its medical staff against such action.
2. Within the framework of clinical governance, Trusts may be encouraged to introduce systems and protocols to monitor, and even direct, the use of licensed and unlicensed medicines. Current exemptions in the Medicines Act mean the prescription of an unlicensed medicine is not considered to be a breach of the duty of care if that treatment was supported by a respected body of medical opinion. The best evidence available should always inform the prescription of medicines for children.

- *'Medicines for Children' (ISBN 1-900954-38-9) is available from B&MBC Books, telephone 01425 471525.*
- *The generic patient information leaflets may be downloaded form the RCPCH web site: www.rcpch.ac.uk/library or by writing to the college at 50, Hallam St, London W1W 6DE.*

References

1. 'A paediatrician's guide to the UN Convention on the Rights of the Child'. *London: British Paediatric Association, 1995.*
2. *A Report of the Joint Working Party of the British Paediatric Association and the Association of the British Pharmaceutical Industry.* 'Licensing Medicines for Children'. *London: Royal College of Paediatrics and Child Health, 1996.*
3. 'Good Medical Practice'. *London: The General Medical Council, 1998.*
4. 'Seeking patients' consent: the ethical considerations'. *London: The General Medical Council, 1999.*
5. 'Letter to the President, British Paediatric Association 3 November 1993'. *Department of Health.*

Our third article, looking in depth at 'Pharmacy in the Future: Implementing the NHS Plan', examines possibly the most controversial section – on changing the pharmacy contract

Only the best will survive

The Government wants to revamp the NHS contract with incentives to encourage the best pharmaceutical care. But behind the promise of rewards lie veiled threats that today's contractors may not be the ones offering these improved services, and rewards for one pharmacy might impoverish another.

When parliamentary time allows, the Government will introduce legislation to allow a new form of agreement between the NHS, pharmacists and pharmacy owners. Pharmaceutical services will be provided under locally tailored arrangements, similar to personal medical services and free from the restrictions of the rigid national remuneration system.

Once the legal framework is in place, the Government will invite proposals from health authorities for pilot schemes to test innovative ways of contracting for pharmacy services. As well as dispensing, these services could include medicines management, health promotion and disease prevention, all within a single agreement.

For the first time, agreements will be possible with individual named pharmacists as well as pharmacy owners. Services will be designed with patients' needs in mind. "And pharmacies will be rewarded according to how well they meet those needs, not just for doing what every other pharmacy has to do," the strategy document states.

The Department of Health will discuss with the Pharmaceutical Services Negotiating Committee changes in the terms of service and distribution of the global sum to establish minimum standards and reward high-quality services, not just volume of prescriptions. Pharmacies providing the best services will gain at the expense of those that are prepared only to provide the minimum.

Speed, efficiency, clinical quality of services, premises standards, the provision of private consulting areas, good record keeping, patient information, continuing professional development and clinical governance will all be taken into account.

"No pharmacy should have the option of standing still while standards elsewhere are rising."

Pharmacists will have to accept some change is now inevitable

Seeds of doubt

Andrew McCoig, Croydon Local Pharmaceutical Committee secretary, regards the proposals with suspicion. There is no promise of investment to help pharmacies improve. Instead there are hints that the Government could impose further requirements on pharmacies before they can receive a basic practice allowance. Pharmacies with the best facilities, including private consultation areas, could receive a higher allowance, while the rest might receive less than they do now. All this could be done under the present contract without the need for primary legislation.

He doubts whether parliament would regard pharmacy as a high enough priority to devote time for legal changes in the near future.

"My increasing feeling is that pharmacy has never reached the top of the political agenda because we perform well and there are few complaints about us, compared with hospitals that have bodies lying around on trolleys, doctors who kill people and surgeons who cut off the wrong limbs," he says. In real terms pharmaceutical expenditure has fallen below other sectors of the NHS. Contract changes would result in more money being spent and the general attitude is "if it ain't broke don't fix it".

He suspects the strategy document is a sop to satisfy the pressure groups in pharmacy. He sees it as a wish list that recognises what pharmacists should be doing, without providing an adequate and fair structural and financial framework to achieve the goals set out.

"I don't see the contract changing in my lifetime [he's 52] unless we're going to be bullied into satisfying more conditions before we qualify for the basic practice allowance."

Wally Dove, PSNC chairman, agrees that slots for primary legislation will be precious in the run-up to the election, so he doubts whether much, if any, of the strategy will be implemented during the Government's current term.

"The controversial areas are likely to be left until after the next election," he believes.

On the chances of increased funding, he says: "As always PSNC will be keen to get more money into the equation. But we have to be realistic

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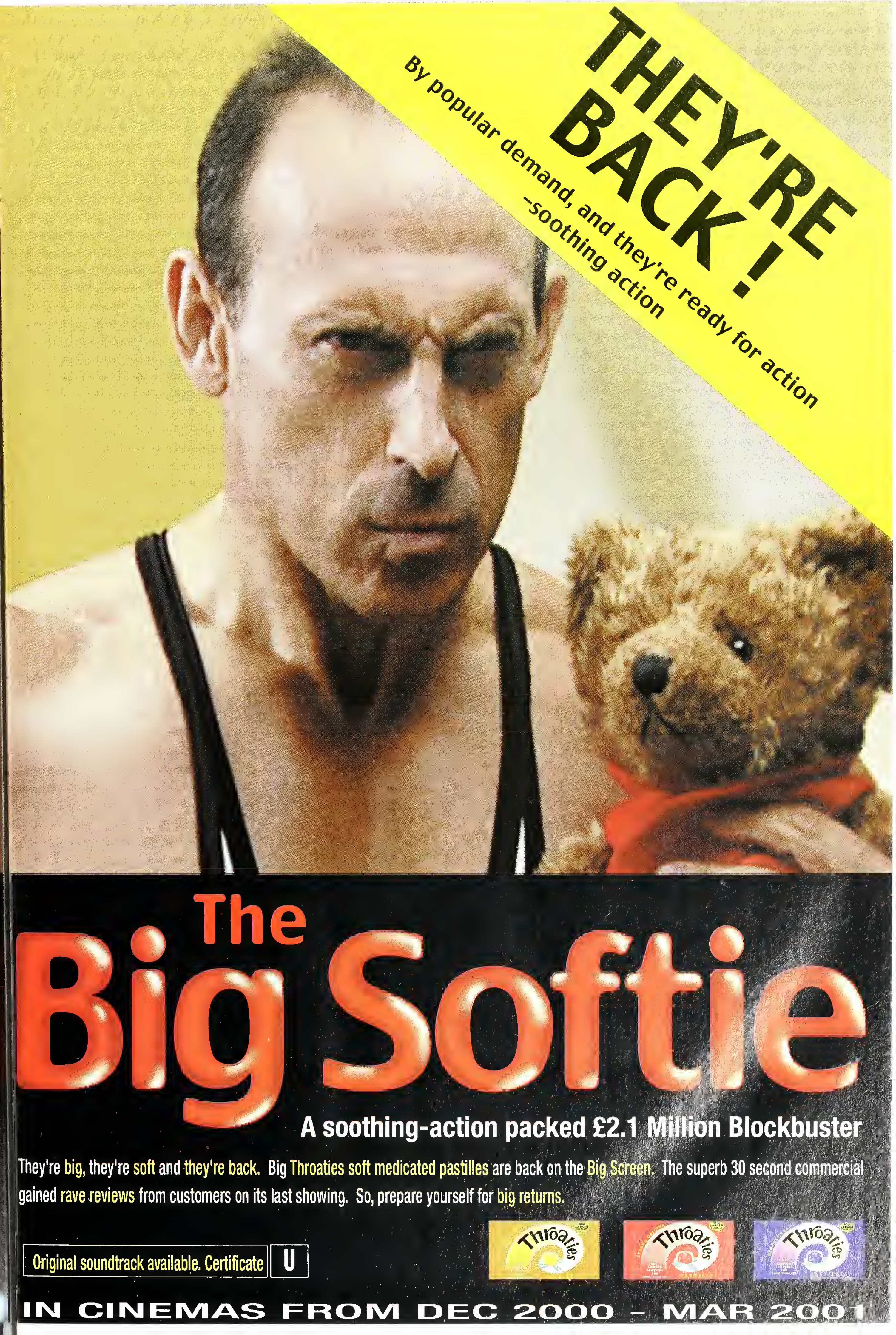
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PLEASE SEE PAGE 88 OF THE UNICHEM DECEMBER PROMOTIONS BOOK FOR PRICING DETAILS.

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and this part of the strategy will need a lot of detailed discussion."

Talks have already started with the Department and he expects there will be several meetings before any agreement is reached.

What does he think might happen to single proprietors who have done their best to provide an efficient service, with good record keeping, clinical advice and so on, yet who find they simply do not have the time to offer extra services? Would they be penalised because they just "did what every other pharmacy has to do?"

Mr Dove says: "The inference is that the opportunity to develop other services is there, and the single-handed may have to co-operate with others in order to do so."

While acknowledging there is a need to improve standards, he says: "One of the physical constraints is that pharmacies don't have elastic walls. Contractors will have to use their imagination if they are to make substantial changes to their premises, otherwise they risk being left behind."

Liverpool LPC secretary Jeremy Clitherow was horrified when he first read the contract proposals, because it seemed the global sum would no longer be ring-fenced for proprietor pharmacists. His fears were confirmed when he heard that the Department of Health intended to implement the pharmacy plan whether or not it had the profession's support. Andrew McKeon, head of the Department's medicines, pharmacy and industry division, told the School of Pharmacy Charter dinner that the aim was to put the plan into effect and hope the pharmacy bodies would help work out the details.

Mr Clitherow interprets the proposals as requiring all extra services to be funded under the global sum, with no extra money on offer.

"If contractors are not capable of or willing to perform these new duties, the Department is quite prepared to give them to other pharmacists and take the finance from the global sum. The intrinsic value of a pharmacy depends on its profitability, so if this lifeblood is being drained away the goodwill value will be threatened."

PSNC's Wally Dove agrees there could be problems with non-contractor pharmacists wishing to provide services. But it would be too isolationist to try to exclude them. A better option would be to concentrate on making community pharmacy an essential part of the wider world of pharmaceutical services.

Control of entry to go?

The Government will be prepared to change the control of entry rules where there is evidence that they are an obstacle to better services, such as dedicated out of hours pharmacies or new one-stop primary-care centres. Control of entry may even be abolished "in places where the restrictions it imposes on competition between pharmacies clearly cannot be justified".

This statement came as no surprise to PSNC's Steve Axon. He told the recent National Association of Co-operative Executive Pharmacists' conference (*C&D*, October 14, p26) that, ever since the control of entry provisions came into effect some contractors had done everything possible to undermine the regulations or to bend them to their own purposes, purely for commercial gain.

"That is why we have had so many judicial reviews and why we have had so many attempts – albeit unsuccessful – to define a neighbourhood or, worse still, to get around the definition of neighbourhood altogether. The statement in the strategy document could, quite simply, be the Government's solution to the problem set for it by contractors themselves."

The solution, too, was similar to the Royal Pharmaceutical Society's proposal that certain areas should be designated 'open' for the purpose of contract applications.

Mr Axon said it was difficult to argue that control of entry in a shopping complex should differ from that in a rural area unless the concern was convenience and competition rather than access.

"We could end up with a mixture of areas where services are controlled and areas of no control, but who is to say where the line will be drawn?"

One possibility could be for the profession to press for incentives for pharmacy services where they are needed, he said, particularly as the Government is prepared to change the control of entry rules where they are an obstacle to providing better services.

Wally Dove thinks PSNC will have to be realistic and accept that some change is inevitable, because of the many changes outside pharmacy such as shopping habits. Services will have to be where the public want them, he says.

The Royal Pharmaceutical Society's president, speaking at the recent BP Conference, urged the Government to build on the benefits of the existing pharmacy network and not destroy them in any major structural reform.

Christine Glover said: "A large number of our members have invested their entire professional lives and their capital to make the community pharmacy network what it is today."

In the second article in the series John Kerry takes a look at the previously prepared SWOT analyses, with the objective of proposing ways of prioritising and evaluating them for the future good of the business

Analysing SWOT

Jason Bennion

There is no standard formula for looking at a SWOT analysis, since each business has to be treated individually. No two will have identical characteristics and influencing properties. It is therefore not possible to cover all strengths, weaknesses, opportunities and threats, but some of the more common ones and methods of dealing with them are discussed.

Strengths

The task after compiling your list is to put the points in priority order, according to their value to the business.

At the top of the list, should they be on it, come location and service levels.

Location: A prominent main street position will normally have a large passing traffic. The passing traffic has to be turned into passing trade and regular customers. A location close to the GP's surgery is a major strength and indeed opportunity, but only if the heavy volume of potential prescription patients are looked after well. Many pharmacies forget that patients are also customers. They concentrate too much on delivering a slick dispensing service, while failing to persuade their patients to buy anything.

If it is your main strength, location can also be included in the opportunities list, if there is potential for further exploitation.

Service Levels: Good service levels are becoming just as important as good locations and many a pharmacy is building its business at the expense of its better located competitor, because it provides a better service. Don't be fooled into believing that your business is providing just what the customer wants and therefore giving your service level a higher mark than it deserves. If you are not sure about this aspect it is a topic for the customer-research work that will be dealt with in a later article.

Size is a strength and certainly an advantage over a similarly-placed competitor in a smaller premises, but only if it is used properly. There are so many instances of a good little pharmacy beating a large one, merely because the larger pharmacy failed to take full advantage of extra space, while its smaller neighbour used good service, good merchandising, layout, lighting and other tactics to best effect.

Staff: A well-trained, highly motivated, knowledgeable, caring, loyal and polite staff are as important as any other aspect. If you can

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honestly say that yours are, then they are right at the top of the list of strengths.

The Pharmacist: A successful pharmacy business revolves around the pharmacist; one with all of the attributes mentioned above for staff, plus the time and skills to communicate with patients on both a professional and social level is going to win. He or she is a pivotal strength of the business. Any shortcomings need to be discovered and put right.

Customer loyalty: There is no substitute for a loyal customer who has been patronising your pharmacy for so long it has become a habit, it is to be hoped for the right reasons. Customers such as this have two important roles to play in your future success. First of all they bring in friends and family and may persuade them to become your customers too. Secondly, they are your captive audience and if you treat them well and offer them more of what they want or demand, they are the easiest route to increased turnover. These aspects are too often taken for granted and the road to failure is littered with businesses where the true value of a loyal customer base was not recognised.

Weaknesses

Points of weakness are normally within the control of a business and can be overcome.

Poor location: This does not necessarily need to be a total drawback. Many pharmacies have successfully countered a poor location by building on other strengths, such as service, product range, size, decor and fittings, prices etc. Advertising and marketing campaigns will help if you have something special to offer when you persuade customers to visit your shop for the first time.

If your pharmacy's turnover is suffering because it simply is not in the right place to pick up either passing trade or patients with prescriptions and you do not believe that any kind of external advertising or marketing activity will change this situation, relocate.

Poor Service: If you know that you service is poor or have discovered through research that local people regard it as such, there is only one solution.

Small Shop: If you operate from a cramped, unwelcoming, inefficient pharmacy you are probably driving customers into your competitors' arms. Building backwards, sideways, taking over the unit next door or minor relocation have worked well in the past.

Staff: Is any member of your staff frightening customers away because of their attitude, lack of knowledge or inability to communicate? Don't let this problem fester. A customer's first contact with your business is a member of your staff. If that contact is unsatisfactory, it may be the last and the customer will influence his or her friends. Nothing spreads faster than a bad reputation.

If you are unable to bring your staff up to a satisfactory level of training, make use of professional trainers, particularly those within the profession.

Pharmacist: Have you discovered or do you believe that you, or your pharmacist manager, are the weak link in the business? This is a problem that has to be tackled with the same vigour as you would a weak member of staff. Quality training is available from a number of bodies within the profession and courses are available from the DTI and other professional institutes.

Shop layout and decor: Often a pharmacy proprietor knows that aspects of the environment, such as front shop layout, fittings and decor need to be improved, but does not want to contemplate the upheaval associated with change. However, because remedying this weakness will improve the retail environment, attract customers and increase counter sales, it has to be done. It does not always entail an expensive refit and if you cannot handle all of the planning aspects, ask someone who can.

It is important that weaknesses are identified by objective observation or research and then eliminated or minimised, to prevent them from discouraging customers from patronising your pharmacy.

Opportunities

Opportunities, large and small, are always there, but some need to be identified. Once evaluated and like strengths prioritised, their exploitation become part of your over-all marketing plan. Keeping a diligent watch on your local market, being aware of changing fashions and demands, listening to customers and carrying out local consumer research, will ensure that few opportunities will be lost.

When strengths are developed and built into the business, proprietors have the opportunity to build upon and exploit them. It is not good enough to have a list of strengths if the business does not have the accompanying opportunities to use them. For example, a 2000 sq ft shop has little value in a tiny village off the beaten track. It is the combined strengths that matter.

Your list of opportunities is likely to be a short one, but it can potentially be expanded by customer and market research. However, the wise don't wait for opportunities to come along, but make good of the few lesser, but nevertheless significant ones that do present themselves.

For example, a four-GP health centre could be moving closer to your pharmacy; a major housing development with service shops may be planned for your town; a competitor could be closing or up for sale. When opportunities such as these arise, you should be ready to take advantage of the chances they offer.

> "There is no substitute for a loyal customer who has been patronising your pharmacy for so long it has become a habit"

Local market and customer research may reveal other opportunities, such as demand for new products or services which could fit into your business, or dissatisfaction with an existing retailer. Smaller opportunities like these are more likely to present themselves.

Threats

The above major opportunities can easily turn into threats should one of your competitors take advantage of them. Threats, which are largely beyond your control, can be viewed as milestones in your decision-making process. It could be the new shopping precinct 500 yards away, with free parking and a large multiple pharmacy planned for next year, or the four GPs next door are moving to a new health centre across town.

Other examples could be the car park behind your pharmacy is going to be built on and the council is painting double yellow lines outside your premises. Or the nearby superstore has purchased one of your colleague's businesses and relocated it in the store.

Most threats are not of a potentially catastrophic nature, but local short to medium term problems that must be dealt with. Very often they involve competitive activity, such as a bright new cut-price drug store, a competitor selling all-in-ones at half price, a new mini lab across the road, nearby shops going out of business, or the relocation of a major customer puller (eg Post Office).

These are all problems, but threats of this type will rarely prove fatal.

Jason Bennion

List specifications

Against each and every one of the strengths, weaknesses, opportunities and threats you have listed should be one or more specific activities designed to maximise or minimise them.

It is rarely possible to produce for each an answer that you are confident will work. It is always a good idea to consult a friend or seek professional help, particularly on activities which are either expensive or have an important bearing on the prosperity of the business. Nobody gets everything right and errors can prove costly.

Guess work has no part to play in this process. So for all of the gaps in your plan, all of the questions which remain unanswered and the activities you are planning, minimise or eliminate the risks of getting it wrong by carrying out research. Of which more in the next article, which will look at methods of setting up customer research projects.

Unichem comes up trumps in *Daily Telegraph* award

Unichem has seen off high calibre competition to win the *Daily Telegraph* Energis Customer Service Award 2000 in the Retail and Distribution category.

Having been shortlisted from originally 242 other public sector companies, Unichem beat established names such as Carphone Warehouse, Dixons and Iceland Foods into second place in the final stages of the competition.

"Quite clearly to win against tough competition like this and in a customer service award is very pleasing. The important thing is that we had an outside company [Energis] effectively tell us that we excel in customer service," said Martyn Ward, Unichem's sales and marketing director.

Customer care standards were judged on the basis of detailed submissions by the company, customer interviews and anonymous service verification checks. The panel of judges is said to have been particularly impressed with two of Unichem's recent customer service initiatives.

The Counter Attack scheme allows customers to buy OTC products in splits. Peter Skinner, Unichem's marketing controller, believes that the scheme can potentially help pharmacists win back some of the lost OTC sales by getting the stock levels right, alongside the right merchandising and right promotions.

Spoc, or single point of contact, ensures that customers can speak to the same customer service clerk every time, thus building up a personal relationship. Customers will also receive a weekly phone-call from their 'spoc' to check everything is working alright.

After celebrating the award, internal and external communications are Mr Ward's next priorities. "Communicating our success to our staff is important. This is not a head office award - every branch, every depot and every van driver has had a part in it," he said.

● UniChem has arranged a deal with Southern Electric that it claims will enable pharmacists to save up to £64 a year by switching to the electricity supplier. The saving is based on an average energy consumption of less than 12,000kW per year, equivalent to an annual bill of around £1,000. Pharmacists with higher bills can save up to 20 per cent, according to UniChem. For more information call Southern Electric on 0845 6000 661 and mention UniChem.

Unichem's winning team at the *Daily Telegraph* Energis Customer Services Awards. From left to right: Kevin Hussey (Energis), Peter Skinner (Unichem's marketing controller), gala host Fiona Bruce (BBC News and Crimewatch presenter) Christ Etherington (managing director Unichem), Geoff Mellor (Unichem's depot manager at Hinckley), Martyn Ward (Unichem's sales and marketing director)

Lib Dems propose central drugs purchasing agency

The Liberal Democrat's Shadow Health Secretary, Nick Harvey, has proposed a central drugs purchasing agency which, he says, could save the NHS £3.4 billion over five years.

Writing in *The House Magazine* - a parliamentary monthly - the MP for North Devon said that, despite the National Plan's efforts to co-ordinate the nation's healthcare, there were many areas that still needed to be addressed.

Pointing to the UK's £7 billion annual drugs bill, he wrote: "and yet pharmaceuticals are purchased in a kind of arrangement that now belongs in smoke-filled rooms."

He felt that a centralised drugs-purchasing agency would bring "accountability and transparency to the murky world of pharmaceuticals" and would "generate enough savings to end the lottery of postcode prescribing".

Waiting for Godot

The Community Pharmacy Action Group was in high spirits this week following the Court of Appeal ruling which led to the suspension of the entire panel hearing the resale price maintenance case.

While a lot is going on in the background, CPAG finds itself in "the middle of a vacuum", waiting for the Appeal Court's judgement to be delivered in writing, as well as the next move from the OFT.

"There is always a possibility that the OFT might appeal to the House of Lords to get the original panel reinstated," CPAG said.

CPAG is, however, adamant that it will have the necessary funds to continue despite the delay. The president of the Restrictive Practices Court, Sir Roger Buckley, has indicated that he would like the case to resume in March next year, but CPAG believes this might not be until after Easter.

Best pharmacy assistant award

The search is on for the pharmacy assistant who is simply "one in a million". Independent pharmaceutical wholesaler Mawdsleys is inviting all its pharmacy customers to nominate their Millennium pharmacy assistant, and explain in no more than 40 words what makes their nominee special.

Deadline for entries to the competition is January 5, 2001, and the winner will receive £250 in vouchers from the shop of their choice.

FSB bails out its flood victims

Pharmacies affected by the recent floods may be eligible for a grant of up to £500 if they are members of the Federation of Small Businesses.

The grants are available to help businesses continue trading and can be used towards the costs of temporary private or business accommodation. Members who are uninsured and have lost everything will be considered for small lump-sum payments.

The organisation has made £20,000 available to each of the seven regions that were affected most by the floods. These include: Kent; East Sussex; Western; South, West and East Yorkshire; North Yorkshire; Shropshire, Herefordshire and Worcestershire; and North Wales regions.

The FSB estimates that it has about 800 pharmacy members. Pharmacists whose businesses were affected by the floods should apply to their local FSB region in the first instance. More information is available at *www.fsb.org.uk*.

COMING EVENTS

DECEMBER 4
Bristol Branch, RPSGB, at the BAWA Leisure Centre, Filton, 7.30 for 8pm. 'IT and Pharmacy - an opportunity for excellence' by Ian Shepherd, information management and technology, RPSGB.
East Kent Branch, RPSGB, at Howfield Manor, Chartham, 7.45pm. 'Reflexology - a demonstration' by Gillian Soutar, MAR.
Eastbourne Branch, RPSGB, Sara Hampson Room, Eastbourne DGH, 8pm. 'Assisted Fertility - what's new?' by Mr D Robertson, FRCOG, director of the Assisted Conception unit, Esperance Hospital, Eastbourne.

DECEMBER 5
Bath Branch, RPSGB, Pratts Hotel, Bath, 7.30 for 8pm. 'National Service Frameworks for Coronary Heart Disease' by Denise Taylor, University of Bath.
Northern Scottish Branch, RPSGB, 7.30pm. 'Tour of Scientific Support Unit, Northern Constabulary, Inverness'.

DECEMBER 6
Stirling and Central Scottish Branch, RPSGB, at the Royal Hotel, Bridge of Allan, 7.45pm. 'A Journey to Bolivia' by Peter Record, committee member.

DECEMBER 7
Lanarkshire Branch, RPSGB, at the Strathclyde Hilton Hotel. 'Quiz Night'.

DECEMBER 7 and 8
NICPPET, at the White Gables Hotel, Hillsborough, 10am-5pm. 'Research Methods in Clinical Practice'.

When Kirit met Tony ...

Possibly the most famous doors in Britain opened for at least one pharmacist this week as Kirit Patel, chief executive of the Day Lewis Group, entered corridors of power.

Mr Patel had been invited to No 10 Downing Street to attend the 'Prime Minister's seminar on support for small businesses'.

Mr Patel told Tony Blair that one of the major problems pharmacy had was that the various government departments often did not seem to pull in the same direction.

"The problem as I see it is that the Government is not as joined up as it makes out to be. On the one hand you have got the Office of Fair Trading and the Department of Trade and Industry trying to abolish Resale Price Maintenance, and on the other hand you have got the DoH/NHSE wishing to extend the role of pharmacists," Mr Patel explained.

Questioned by the Prime Minister on his opinion of the National Plan, Mr Patel congratulated the Government on this document but pointed out that there was no mention of new money being made available.

"The Treasury needs to make a medium to long-term investment to promote pharmacists role," Mr Patel said. He added that this would not only benefit the healthcare provision in the UK but that eventually the additional spending could be recouped by keeping patients out of hospital with pharmacists' help.

Kirit Patel, chief executive of the Day Lewis Group, pictured far left, attending the Prime Minister's seminar on support for small businesses

Tony Blair had earlier outlined the Government's plan for small businesses and promised to ease the bureaucratic burden on them by cutting back unnecessary business regulations and simplifying existing ones, and streamlining the employment tribunal system. A third measure was the introduction of a new code of practice on written consultations.

The meeting was also attended by Small Firms and e-commerce Minister Patricia Hewitt, Treasury Minister Dawn Primarolo, David Irwin (chief executive of the small business service), Chris Humphries (British Chambers of Commerce) and William Sargent (Small Business Council).

ABPI calls for breathing space from NICE

The Association of the British Pharmaceutical Industry (ABPI) has called for a "window of opportunity" allowing new medicines to be used before they are assessed by NICE (National Institute for Clinical Excellence). The time would be used to collect reliable evidence about the clinical and cost-effectiveness of the drug. The ABPI said this would ensure that NICE's appraisal could then be carried out on the basis of sound data.

The ABPI warned that under the current system there was a real risk that pharmaceutical companies would be increasingly unlikely to choose the UK as the primary market for a product launch, so jeopardising the UK as a base for future Research and Development.

"There is no doubt that new and better medicines will arrive. The big unanswered question is whether British scientists will be encouraged to develop them and whether NHS patients will be able to reap the benefits," said Dr Trevor Jones, ABPI director general.

The ABPI also called for the spending of funds committed to implementing NICE's guidance to be monitored and pressure put on health authorities who use NICE as an excuse not to take up new medicines.

oots is planning to open a urther 38 Chiropody and ootcare practices by the nd of March 2001, nvesting £6m in the enture. The stores will be ituated alongside Boots entalcare in existing stores ationwide. The company aid the pilot with six such ractices had exceeded xpectations in terms of ourly income and ccupancy rates. According Boots, 18,000 patients ave registered with the hiropody and Footcare ractices so far

Safeway plans more room for pharmacy

Safeway plans to increase its involvement in pharmacy as part of the company's overall strategy to expand the non-food area of its business, announced last week.

Over the next two years 25 Safeway stores will be converted into hypermarkets which will be created by increasing the selling space of existing outlets.

As medicines and health and beauty products are classified as non-foods, the floor space for these products may also be increased, according to Paul Bennett, superintendent pharmacist.

"In the past, a lack of space has had an impact on the number of pharmacies we have opened. This gives us an opportunity to pursue our ambition to acquire more pharmacy contracts and will help our plans to accelerate the rate at which we open more pharmacies," Mr Bennett said.

"If a store that is being extended already has a pharmacy, this will then give us the opportunity to re-position or expand that pharmacy," he added. Safeway currently has 107 pharmacies.

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Please note December 23rd and 30th issues will be combined.
The deadline for this is 12 noon on December 19th.

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Ulster Chemists have a ball!

Ulster pharmacists were on their best behaviour last weekend - it was, after all, the Ulster Chemists Association Ball at Belfast's Europa Hotel. "It's our 15th wedding anniversary next month," confided one allegedly hard-done-by wife. "You'd have got out a lot earlier if you had signed up to the Good Friday agreement sooner," was the deadpan response from a passing colleague.

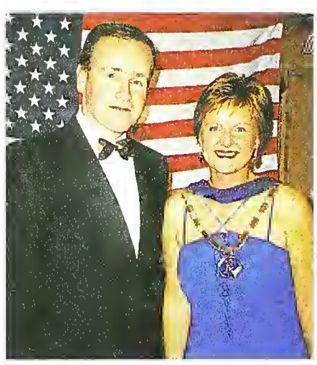
Journalists perked up for a potential news story when NPA director John D'Arcy briefly became interested in Zen and the art of motorcycle maintenance. He had won a prize in the raffle - 'Be an Easy Rider for a weekend on your own Harley Davidson'. Wife and Mallinson House forgotten, you could see his eyes mist over and his wrist flex on the throttle. Unfortunately he crashed and burned at the first bend as the offer had to be taken up locally. Still, the 20in colour television he took away instead will fit well in the office.

With it being the weekend after Thanksgiving (a pagan US festival), there was an American theme. Bill and Hillary were doing the rounds, and Mickey was much in evidence.

UCA president Fiona Harte encouraged pharmacists to "jump together" with a united front to face the challenges ahead, and warned that the UCA soon hopes to establish itself on the information superhighway. And, finding herself short of a guest speaker, she paid a poignant tribute to the late Ronnie McMullan.

Meanwhile the raffle raised £1,415 for CRISP, a charity which supports parents of children who suffer from cerebral palsy.

Numark's Terry Norris links arms with some colourful local characters



NPA director John D'Arcy with UCA president Fiona Harte

Adam Smith knew all about RPM in 1776

Thanks to the Scottish Pharmaceutical Federation, we are reminded about the prescient writings of an eminent economist, Adam Smith.

Hailing from Kirkcaldy, Fife, where the current Chancellor, Gordon Brown, grew up, Adam Smith wrote the great treatise on economic liberalism, the 'Wealth of Nations'. Published in 1776, the work looks at economic freedom and has been adopted as the basis of free enterprise.

An interesting passage in the book relates to the humble apothecary.

"Apothecaries' profit is become a bye-word, denoting something uncommonly extravagant. This great apparent profit, however, is frequently no more than the reasonable wages of labour. The skill of an apothecary is a much nicer and more delicate matter than that of any artificer whatever; and the trust which is reposed in him is of much greater importance. He is the physician of the poor in all cases, and of the rich when the distress or danger is not very great. His reward, therefore, ought to be suitable to his skill and his trust, and it arises generally from the price at which he sells his drugs.

"But the whole drugs which the best employed apothecary, in a large market town, will sell in a year, may not perhaps cost him above thirty or forty pounds. Though he should sell them, therefore, for three or four hundred, or at a thousand per cent profit, this may frequently be no more than the reasonable wages of his labour charged, in the only way in which he can charge them, upon the price of his drugs. The greater part of the apparent profit is real wages disguised in the garb of profit."

Were these words repeated at the Restrictive Practices Court in the resale price maintenance hearing, we wonder?

Mini-marathon man

If you're going to run your first half marathon, you can't do much better than the Great North Run. So congratulations to pharmacist Grahame Rowley, who raised £760 for Francis House, a children's cancer charity in Didsbury, Manchester. Mawdsley-Brooks generously agreed to sponsor him for the event. "At 10 miles there was a huge hill to climb but when you know that there is a lot of money for charity at stake you know that you have to keep going - you know you've got plenty of time to recover afterwards," says Mr Rowley. "It was an absolutely fantastic atmosphere, and that helped too."

Philip Bradley, Mawdsleys' marketing manager, says: "We are pleased to hear about our customers' charity efforts and congratulate Grahame on completing his run."

A company's history is often so dry that it barely gets a glance. The Bayer Tapestry (with apologies to 1066 And All That) presents a unique solution to the problem. As it is 12ft or so, we cannot reproduce it all, but this section gives a flavour. "Bayer cannot claim great antiquity ... nevertheless our history remains a rich tapestry of invention, discovery and positive development that goes beyond science, chemistry and research into all our daily lives." Say it with pictures is definitely our recommendation!

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